

**Public health:  
Community learning disability nurses'  
perception and experience of their role –  
An exploratory sequential multiple methods study**

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## CONTENTS

<b>List of boxes, figures, and tables</b>	<b>v</b>
<b>List of appendices</b>	<b>viii</b>
<b>Dedication</b>	<b>ix</b>
<b>Acknowledgements</b>	<b>x</b>
<b>Abstract</b>	<b>xi</b>
 <b>INTRODUCTION</b>	 <b>1</b>
 <b>SECTION 1: REVIEW OF THE LITERATURE AND RATIONALE</b>	
<b>Introduction</b>	<b>5</b>
<b>Chapter 1: Context</b>	<b>6</b>
Introduction	6
1.1 Literature review strategy	6
1.2 Public health policy and learning disability	10
1.3 Learning disability policy	16
1.4 Health needs of people with learning disabilities	21
1.5 Public health policy implementation and people with learning disabilities in the UK	27
1.6 Conclusion	39
<b>Chapter 2: The nature of role theory and application to nursing</b>	<b>41</b>
Introduction	41
2.1 The origins of role theory	41
2.2 Organisational and cognitive role theories	54
2.3 Role theory in community learning disabilities nursing	60
2.4 Purpose of job descriptions	63
2.5 Conclusion	73
 <b>SECTION 2: RESEARCH METHODS</b>	
<b>Introduction</b>	<b>74</b>
<b>Chapter 3: Study design</b>	<b>76</b>
Introduction	76
3.1 Cosmology, ontology, and epistemology	77
3.2 Overview of study design	79
3.3 The research paradigm divide	83
3.4 Multiple methods	90
3.5 Sequential multiple methods	103
3.6 Ethical considerations	105
3.7 Conclusion	107

<b>Chapter 4: Stage 1 – Documentary analysis (exploratory phase)</b>	<b>108</b>
Introduction	108
4.1 The documentary method	108
4.2 Documents	111
4.3 Sampling	113
4.4 Preparing data for analysis	121
4.5 Data analysis	122
4.6 Validity and reliability considerations	130
4.7 Conclusion	131
<b>Chapter 5: Stage 2 – Semi-structured interviews (descriptive phase)</b>	<b>132</b>
Introduction	132
5.1 Grounded theory	133
5.2 Sampling and participant recruitment	137
5.3 Data collection	143
5.4 Data analysis	144
5.5 Validity and reliability of grounded theory analysis	149
5.6 Conclusion	155
<b>Chapter 6: Stage 3 – Questionnaire survey (explanatory phase)</b>	<b>157</b>
Introduction	157
6.1 The survey method	158
6.2 Survey questionnaire development	160
6.3 Sampling and participant recruitment	164
6.4 Data collection	170
6.5 Data analysis	170
6.6 Validity and reliability considerations	176
6.7 Conclusion	177
<b>SECTION 3: RESULTS</b>	
<b>Introduction</b>	<b>179</b>
<b>Chapter 7: Results 1 – Documentary analysis</b>	<b>181</b>
Introduction	181
7.1 Data analysis stage 1 – A priori theoretical categories	183
7.2 Data analysis stage 2 – Word frequencies	184
7.3 Data analysis stage 3 – Free nodes	184
7.4 Data analysis stage 4 – Initial codes	237
7.5 Data analysis stage 5 – Initial themes	239
7.6 Data analysis stage 6 – Themes	240
7.7 Data analysis stage 7 – Densified themes (roles and policies)	240
7.8 Summary of findings	241
7.9 Conclusion and key findings	242

<b>Chapter 8: Results 2 – Semi structured interviews</b>	<b>244</b>
Introduction	244
8.1 Data analysis stage 1 – Open coding (1)	244
8.2 Data analysis stage 2 – Code clusters	245
8.3 Data analysis stage 3 –Referenced ‘line-by-line’ data extracts	245
8.4 Data analysis stage 4 – Open coding (2)	266
8.5 Data analysis stage 5 – Axial coding	267
8.6 Data analysis stage 6 – Theoretical coding	269
8.7 Data analysis stage 6a – Selective coding (role moderators)	269
8.8 Data analysis stage 6b – Selective coding (roles and policy)	270
8.9 Data analysis stage 7 – Integration	271
8.10 Data analysis stage 8 – Memoing and diagramming	272
8.11 Summary of findings	274
8.12 Conclusion and key findings	275
 <b>Chapter 9: Results 3 – Questionnaire survey</b>	 <b>276</b>
Introduction	276
9.1 Nurse distribution by band and employer	277
9.2 Explanatory phase questionnaire reliability test results	278
9.3 Correlations	279
9.4 ANOVA	281
9.5 Role clarity in job descriptions	286
9.6 Role review	288
9.7 Daily activities	291
9.8 Role perception	293
9.9 Perceived role value	295
9.10 Public health roles	295
9.11 Perceptions of employers’ priorities	300
9.12 Perceptions of employers’ knowledge	302
9.13 Summary of findings	305
9.14 Conclusion and key findings	308
 <b>SECTION 4: DISCUSSION</b>	 <b>310</b>
Introduction	310
<b>Chapter 10: Policy involvement roles</b>	<b>311</b>
Introduction	311
10.1 Policy involvement	311
10.2 Role clarity	317
10.3 Policy implementation roles	322
10.4 Policy dissemination roles	335
10.5 Policy development roles	345
10.6 Policy evaluation roles	347
10.7 Conclusion	348

<b>Chapter 11: Moderators of public health role enactment</b>	<b>349</b>
Introduction	349
<b>Cause families of public health role moderators</b>	<b>352</b>
11.1 Role clarity in job descriptions	352
11.2 Role review	355
11.3 Consistency of role expectations with daily activities	357
11.4 Role perception and perceived role value	358
11.5 Type of employer	359
11.6 Employer priorities	362
11.7 Perceptions of employer's knowledge of public health needs of people with learning disabilities	363
11.8 Band	364
11.9 Public health role expectations	367
11.10 Dialogical definitions	371
11.11 Demographic ignorance	374
11.12 Professional silo mentality	377
11.13 Organisational silo mentality	378
11.14 Policy formulation and implementation vacuum	380
11.15 Leadership vacuum	381
<b>Context families of public health role moderators</b>	<b>383</b>
11.16 Centralisation <i>versus</i> decentralisation	383
11.17 Policy process	385
11.18 Resource constraints	386
<b>Process families of public health role moderators</b>	<b>387</b>
11.19 Organisational culture, change, and inertia	387
11.20 Policy conflict	391
11.21 Political power and influence	392
<b>Consequence families of public health role moderators</b>	<b>392</b>
11.22 Inter-agency and philosophical tensions	392
11.23 Role encroachment	394
11.24 Role validation behaviour	395
11.25 Role extension	397
11.26 Conclusion	398
 <b>Chapter 12: Conclusions, strengths, weaknesses and         recommendations</b>	 <b>400</b>
Introduction	400
12.1 Research's contribution to knowledge	400
12.2 Strengths of the study	403
12.3 Weaknesses and limitations of the study	405
12.4 Implications of the study	406
12.5 Conclusion	410
12.6 Recommendations	412
 <b>References</b>	 <b>421</b>
<b>Appendices</b>	<b>488</b>

## LIST OF BOXES, FIGURES, AND TABLES

Box 1a: Key areas of public health practice (UK Faculty of Public Health)	12
Box 9a: Interpretation of mean scores	276
Figure 1c: Perspectives of policy implementation – summaries	31
Figure 3a: Study design	82
Figure 4a: Illustration of how job descriptions were sampled	121
Figure 5a: Illustration of constant comparative analysis activities	145
Figure 5b: Process of independent review of findings (Stage 2)	154
Figure 6a: Explanatory phase sample calculation	168
Figure 7a: Band 5 nurses' public health role expectations	185
Figure 7b: Band 5 job descriptions policy references	194
Figure 7c: Band 6 nurses' public health role expectations	199
Figure 7d: Band 6 job descriptions policy references	206
Figure 7e: Band 7 nurses' public health role expectations	213
Figure 7f: Band 7 job descriptions policy references	221
Figure 7g: Band 8 nurses' public health role expectations	231
Figure 7h: Band 8 job descriptions policy references	236
Figure 8a: Cause families of public health role moderators	246
Figure 8b: Context families of public health role moderators	255
Figure 8c: Process families of public health role moderators	258
Figure 8d: Consequence families of public health role moderators	262
Figure 8e: Descriptive phase data analysis stage 7 (integrated relationships and core categories)	272
Figure 9a: Nurse distribution by band and employer	277
Figure 9b: Means plot ( <i>band</i> )	283
Figure 9c: Means plot ( <i>type of employer</i> )	286
Figure 9d: Role clarity in job descriptions means plots	287
Figure 9d1: Distribution of scores for Q1 – ' <i>role clarity</i> '	288
Figure 9e: Role review means plots	289
Figure 9e1: Distribution of scores for Q2 – ' <i>role review</i> '	290
Figure 9f: Daily public health role activities means plots	292
Figure 9f1: Distribution of scores for Q3 – ' <i>consistency of role expectations</i> '	293

Figure 9g: Role perception means plots	294
Figure 9g1: Distribution of scores for Q4 – ‘ <i>role perception</i> ’	295
Figure 9h: Perceived role value means plots	296
Figure 9h1: Distribution of scores for Q5 – ‘ <i>perceived role value</i> ’	297
Figure 9i: Band 5 nurses’ involvement with public health	298
Figure 9j: Band 6 nurses’ involvement with public health	298
Figure 9k: Band 7 nurses’ involvement with public health	299
Figure 9l: Band 8 nurses’ involvement with public health	300
Figure 9m: Perceptions of employer’s priorities means plots	301
Figure 9m1: Distribution of scores for Q7 – ‘ <i>perceptions of employer’s priorities</i> ’	301
Figure 9n: Perceptions of employer’s knowledge means plots	304
Figure 9n1: Distribution of scores for Q8 – ‘ <i>perceptions of employer’s knowledge</i> ’	305
Figure 11a: Moderators of public health role enactment	351
Table 1a: The stages model in the policy cycle	28
Table 1b: Perspectives of policy implementation – comparisons	37
Table 2a: Definitions of role	53
Table 2b: Major models of role theory	55
Table 2c: Extracts from the National Profiles of community learning disability nurses	70
Table 2d: The NHS Knowledge and Skills Framework – Dimension HWB1	71
Table 2e: Public health role descriptors (expectations)	72
Table 4a: Details of job descriptions	115
Table 5a: Descriptive phase participants	141
Table 5b: Stage 2 participants biographical data	142
Table 6a: UK NMC registered learning disability nurses	165
Table 6b: Stage 3 participants biographical data	169
Table 6c: Data codes for explanatory phase analysis	172
Table 6d: Pearson correlations interpretation guide	173
Table 7a: UK National Profiles of community learning disability nurses’ public health roles	183



Table 7b: <i>A Priori</i> theoretical categories	184
Table 7c: Exploratory phase initial codes (public health role expectations and policy references)	238
Table 7d: Exploratory phase axial codes and initial themes	239
Table 7e: Exploratory phase public health policy implementation themes	240
Table 7f: Exploratory phase themes (policy and policy implementation roles)	241
Table 8a: Descriptive phase data analysis stage 4 (open codes)	267
Table 8b: Descriptive phase data analysis stage 5 (axial codes)	268
Table 8c: Descriptive phase data analysis stage 6 (theoretical codes)	269
Table 8d Descriptive phase data analysis stage 6a (selective codes – role enactment moderators)	270
Table 8e: Descriptive phase data analysis stage 6b (selective codes – roles and policy)	271
Table 8f: Example of memoing (roles)	273
Table 8g: Example of memoing (coding families)	273
Table 9a: Explanatory phase questionnaire reliability test results	278
Table 9b: Interpretations of the relationships between variables (Stage 3)	280
Table 9c: Levene's statistic test results (band)	281
Table 9d: Between bands ANOVA test results (band)	281
Table 9e: Tukey's HSD post-hoc test results (band)	282
Table 9f: Levene's statistic test results (employer)	284
Table 9g: Between employer groups ANOVA test results	284
Table 9h: Tukey's HSD post-hoc test results (employer)	285
Table 11a: Public health involvement summary of response rates	368

## LIST OF APPENDICES

Appendix 1a: Emerging themes – <i>A priori</i> literature review	489
Appendix 1b: Publication paper 1	492
Appendix 1c: Publication paper 2	497
Appendix 1d: Publication paper 3	500
Appendix 1e: Publication paper 4	503
Appendix 3a: Multiple methods design checklist (Creswell 2009, p205)	512
Appendix 3b: Ethics approval letter (Stages 1 and 2)	513
Appendix 3c: Ethics approval letter (Stage 3)	514
Appendix 3d: Invitation letter and consent form (Stage 2)	515
Appendix 3e: Invitation letter and consent (Stage 3)	517
Appendix 5a: Interview protocol and interview questions (Stage 2)	519
Appendix 6a: List of learning disability nurses' professional networks (Stage 2)	520
Appendix 6b: Online survey questionnaire (Stage 3)	522
Appendix 6c: Participant invitation e-mail (Stage 3)	525
Appendix 7a: Word frequencies (examples) (Stage 1)	527
Appendix 7b: Initial free nodes (public health roles) (examples) (Stage 1)	528
Appendix 7c: Ranked summary of roles by band (Stage 1)	529
Appendix 7d: Ranked summary of policies by band (Stage 1)	530
Appendix 8a: Data analysis stage 1 – Referenced 'line-by-line' data extracts (Open Codes) (examples) (Stage 2)	531
Appendix 8b: Data analysis stage 2 - Code clusters (examples) (Stage 2)	537
Appendix 9a: Correlation matrix of group variables (n = 171) (Stage 3)	538
Appendix 9b: Correlation matrix of combined variables (n = 171) Stage 3)	539

## **Dedication**

This thesis is dedicated to my mother who single-handedly raised me, following the untimely passing of my father when I was 5 years old. She laid the foundations of one of the values that underlie my ontological position, and that is, ‘...*to leave the world a better place...*’ (Ralph Waldo Emerson). Without these values this work would not have been possible.

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## **Abstract**

### **Purpose**

Research into how public health policy is translated into role specifications within job descriptions of community learning disability nurses is important. In addition, the need for research that focuses on describing how community learning disability nurses perceive, and enact their public health roles has been identified. Furthermore, there is need to explain the ‘moderators’ of how community learning disability nurses enact their public health roles.

### **Methods**

This was a 3-stage exploratory sequential multiple methods study. Stage 1 was documentary, and involved collecting and analysing community learning disability nurses’ job descriptions, and or person specifications. Stage 2 was descriptive, and used a grounded theory approach. Stage 3 was explanatory, and involved an on-line questionnaire survey.

### **Main findings**

There were inconsistencies in public health role expectations in community learning disability nurses’ job descriptions and person specifications. The public health roles were academic, health education, health prevention, health promotion, health protection, health surveillance, healthcare access facilitation, healthcare delivery, leadership, and policy development and implementation. The moderators of public health role enactment by community nurses identified in this study were complex and extended beyond current explanations of role theory. Some of the correlates of the moderators of public health role enactment by community learning disability nurses included role clarity in job descriptions, periodic review of role expectations, role

perception, perceived role value, community learning disability nurses' perceptions of employing organisations' priorities, and community learning disability nurses' perceptions of employing organisations' knowledge of the public health needs of people with learning disabilities, band, and finally the type of employer.

### **Significance for research and practice**

There is a need for clarity of community learning disability nurses' public health roles locally, and nationally. It is important that relevant organisations have structures that can respond appropriately to public health policy changes in order to meet the often complex and co-morbid health needs of people with learning disabilities.

## **INTRODUCTION**

This study has investigated how community learning disability nurses enacted their public health roles, and thereby contributed to role theory, and public health policy implementation for people with learning disabilities. While a limited number of exploratory, and descriptive studies exist in this subject area, there is a dearth of explanatory studies. An examination of existing literature showed that there was need to move from studies which create, replicate role lists, and describe roles, tasks, and functions of community learning disability nurses. There is a need for inductive, and deductive studies to ascertain the nature, and extent of the involvement of community learning disability nurses in public health policy implementation for people with learning disabilities. This study had three key aims. Firstly, this study explored how public health policy was reflected, and articulated in community learning disability nurses' job descriptions, and or person specifications. Secondly, the study sought to describe, and hypothesise how community learning disability nurses interpreted and enacted their public health roles. Thirdly, the study sought to explain moderators of how community learning disability nurses enacted their public health roles in implementing public health policy for people with learning disabilities in the context of role theory. This was a 3-stage sequential multiple method study which covered England, Wales, Scotland and Northern Ireland. Details of the design of the study are given in chapter 3. (Originally this was a 4-stage study. Rationale for alterations is discussed in chapter 3). The study sought to answer one key question and three subsidiary questions, and these are:

**Key question:**

***What are the public health roles of the community learning disability nurse, and what are the moderators of how they enact their public health roles?***

**Subsidiary questions:**

- a. ***How is public health policy reflected in community learning disability nurses' job descriptions, and person specifications?***
- b. ***What is the community learning disability nurse' perception of the moderators of how they enact their public health roles?***
- c. ***What are the correlates of public health role moderators of how community learning disability nurses enact their public health roles in implementing public health policy for people with learning disabilities?***

Community learning disability nursing in the UK can be traced back to the 1970s. However, there is no legal, or professional definition of community learning disability nursing. Furthermore, the four countries of the UK do not provide a working definition of community learning disability nursing. The Royal College of Nursing has attempted to define community learning disability nursing (RCN 1992). This definition has traditionally been accepted in practice, but this is constraining and no longer adequate. This is because role of community learning disability nurses has evolved, and continues to evolve in the practice setting (Boarder 2002; Mobbs *et al* 2002; Barr 2006). In addition, although no specific studies have investigated the drivers for these changes, recent reviews of policies for people with learning disabilities has led to the re-organisation of services across the UK (DH 2001; Department of



Health, Social Services and Public Safety 2004; Scottish Executive 2000; Welsh Office 2001). Furthermore, the *NHS Knowledge and Skills Framework* has outlined role expectations for community learning disability nurses in the UK (DH 2004b). In light of the absence of an unambiguous definition of 'community learning disability nurse', it is important to clarify the meaning for the purpose of this study. In this study, 'community learning disability nurse' refers to Nursing and Midwifery Council 'learning disabilities nurse' RN5 or RNLD registrant whose role involves provision of nursing care to people with learning disabilities in a wide range of community settings. In the context of this study, the 'community learning disability nurse' work in a multi-disciplinary team, holds a caseload, and, admits and discharges people with learning disabilities who have health needs. While previously the title 'community learning disability nurse' was predominantly used in community learning disability nursing, the developments noted here have resulted in a wide range of new job titles for community learning disability nurses.

This thesis is divided into 4 sections. There is an introduction to each section. Further details of the structure of each chapter are contained in the introduction to each of the sections, and the introduction to each of the chapters.

**Section 1** reviews literature pertinent to this study. Chapter 1 sets out the context of the United Kingdom's public health, and learning disability policies in which this study took place. Chapter 2 explores existing literature regarding the nature of role theory, in the context of community learning disability nursing.

**Section 2** explains the research design, and methodological approaches to the study. Chapter 3 outlines the overview of the study design. The aims of the study, ethical considerations, ontological, and philosophical assumptions that underlie the research are also addressed in this chapter. Chapter 4 details the sampling, collection, and analysis of data for stage 1 of the study. Chapter 5 explains the methodology for stage 2 of the research. Chapter 6 is the penultimate chapter in this section, and explains the approach to stage 3 of this study.

**Section 3** contains 3 chapters, which outlines the results of the study. Each stage of the research was independent of each other; and therefore it is appropriate that results for each stage are presented independent of each other. Chapter 7 covers results for stage 1 of this study. Results for stage 2 of this study are given in chapter 8. The last chapter in this section, chapter 9, reports on the findings of stage 3 of this study.

**Section 4** discusses, and concludes the findings of this study. Chapter 10 discusses findings relating to the involvement of community learning disability nurses with public health policy. Role moderators of how community learning disability nurses, who participated in this study, interpreted, and enacted their public health roles are discussed in chapter 11. Chapter 12 is the penultimate chapter of this thesis. Contributions of the research to new knowledge, the strengths and limitations of the study, implications for community learning disability nursing, and recommendations are addressed in this chapter.

## **SECTION 1: REVIEW OF THE LITERATURE AND RATIONALE**

### **Introduction**

In chapter 1, an outline of the literature review strategy is given. The second section discusses current public health policy, and its relevance to learning disability nursing practice. This is followed by an exploration of literature relating to learning disability policy and its relevance to public health. The fourth section explores literature regarding the public health needs of people with learning disabilities. The last section in this chapter explores literature that dealt with how public health policy is currently implemented for people with learning disabilities.

Chapter 2 explores literature that exists regarding the origins, and nature of role theory, and its relevance to community learning disability nursing practice. The second section discusses literature on organisational, and cognitive role theories, and their relevance to community learning disability nursing practice. The third section explores the concepts of role ambiguity, and role clarity. This is followed by an exploration of literature on the current position of role theory in community learning disability nursing practice. The final section in this chapter discusses literature on job descriptions and their significance in role enactment.

## **Chapter 1: Context**

### **Introduction**

This chapter begins by outlining the literature review strategy adopted for this study. This is followed by an exploration of the literature that currently exists regarding public health policy, and its relevance to learning disability nursing practice. Approaches to public health policy implementation in the United Kingdom are also explored. Broad overviews of current learning disability policy in the United Kingdom are then outlined. This leads to an exploration of the literature that highlights the nature, and extent of the health and public health needs of people with learning disabilities. The last section in this chapter reviews literature on how public health policy is implemented for people with learning disabilities.

### **1.1 Literature review strategy**

1.1.1 The purpose of this study was to generate, and contribute new knowledge to our understanding of how community learning disability nurses perceive, interpret, and enact their public health roles, and to locate this within role theory. The study also investigated the involvement of community learning disability nurses in the implementation of public health policy for people with learning disabilities. The study took place in two broad and complex contexts. Firstly, the study took place in the context of the United Kingdom's government's disparate public health policy. Secondly, the study took place in the context of organisational and cognitive role theories. *A priori* review of the literature was therefore central to this research (Cronin *et al.* 2008).

- 1.1.2 A narrative approach to literature review was preferred over the systematic method (Parahoo 2006). The rationale for this was two-fold. Firstly, the qualitative nature of the relevant literature meant that a systematic approach would have been inappropriate. Secondly, the complexity, and extent of the research field necessitated the need to be selective with the literature considered for review (Cronin *et al.* 2008).
- 1.1.3 Extensive literature on key topics in public health exist (Ewles 2005; Naidoo and Wills 2005). A wide range of relevant government public health policy documents exist (DH 1999a; DH 2001; DH 2010; Scottish Government 2008; DHSSPSNI 2002). Many publications on the study of role theory exist (Biddle and Thomas 1966; Biddle 1979; Goffman 1961). In addition, studies exist that investigated community learning disability nursing roles (Jukes 1994; Mansell and Harris 1998; Stewart and Todd 2001; Mobbs *et al.* 2002; Llewellyn and Northway 2007; RCN 1985; Elliot-Cannon 1981; Barr 2006; Barr *et al.* 1999). Finally, some investigations into health policy implementation for people with learning disabilities have been undertaken (Fyson 2002; Boarder 2002).
- 1.1.4 In light of the complexity of the research field in which this study took place the review of the literature was approached in two ways, *a priori* and *ad hoc*. The literature search strategy described in this section relates to the *a priori* stage of the review of literature. In the United Kingdom the government makes on-going changes to public health policy. In addition, new literature and evidence emerge over time. The *ad hoc* approach to literature review was therefore essential in adding new knowledge to the study as it emerged.

However, because of its nature the process of *ad hoc* literature review is not reported, but the literature is embedded throughout this thesis.

1.1.5 The rationale for the *a priori* review of the literature was seven-fold. Firstly, it was important to learn from existing literature in order to develop a clear picture of existing knowledge (Parahoo 2006). The second reason was to set the research project in the context of existing knowledge. In addition, the literature review was important in identifying gaps in knowledge. This was important in rationalising the study. Furthermore, this process also contributed significantly to my theoretical sensitisation, which was essential in how the research questions were developed, and refined over time. Another reason for the *a priori* review of the literature was in developing the theoretical and philosophical frameworks on which the study was built (Cronin *et al.* 2008; Parahoo 2006). Additionally, this was useful in clarifying the school of thought in which the findings of the study would eventually sit (Coughlan *et al.* 2007). Finally, undertaking the *a priori* literature review contributed significantly to the overall research design, methods of data collection, and data analyses adopted (Cronin *et al.* 2008).

1.1.6 The *a priori* literature review focused on two broad groups of studies. The first group covered studies that explored the public health role of learning disability nurses and their involvement with public health policy implementation. The second group covered studies of people with learning disabilities' perceptions, and experiences of accessing public health services.

1.1.7 The approach to literature search involved undertaking computer database searches using EBSCOhost, CINAHL, Academic Search Elite, Ovid Online, IBSS, Index to Theses, PsycARTICLES, ScienceDirect, RCN Journals Database, ZETOC Search, and Google Scholar. The approach was consistently used for both *a priori*, and *ad hoc* searches. For both literature searches, search words were placed into two categories. One category contained key terms, *i.e.*, learning disability, learning difficulty, mental retardation, and intellectual disability. These were combined with words or phrases pertinent to the study; learning disability nurse, community learning disability nurse, role, public health, health promotion, public health policy, healthcare, views, perceptions, experience, user involvement, policy implementation, participation, and consultation. Suitable articles were those:

- that related to public health roles of learning disability nurses, and
- which focused on people with learning disabilities' perceptions and experience of accessing public health services.

1.1.8 Studies were excluded if they were non-English, government documents, and studies covering the 'non-health' roles of learning disability nurses. The search produced 75 articles of relevance. Three very distinct groups of studies emerged, and these are:

- studies which addressed public health roles of the learning disability nurse;
- studies which sought the perceptions, and experiences of people with learning disabilities regarding access to public health / healthcare, and
- studies, which explored the implementation of health policy for people with learning disabilities.

1.1.9 Literature was then read, summarised, and themes identified (see *Appendix 1a*). The themes that emerged were central to the formulation of the research aims and questions. Following the *a priori* literature review, a number of articles were produced for publication in double blind peer reviewed journals (see *Appendices 1b, 1c, and 1d*).

## **1.2 Public health policy and learning disability**

1.2.1 The concept of public health is a contentious one (Dawson and Verweij 2007). Consequently there is no agreed definition of what ‘public health’ means (Baggott 2011; Kaiser and Mackenbach 2008). Given this ambiguity it was important to explore the relevant literature in order to arrive at a working definition for this study. According to Blaxter (2004), this lack of an agreed dialogical definition is not surprising, given that the meaning of ‘health’ itself is a subject of endless debates. The all-encompassing definition of public health (Baggott 2011) is problematic, and a source of significant confusion (Griffiths and Hunter 1999). According to Hunter *et al.* (2010) this lack of conceptual clarity has led to a notable lack of public health influence on health policy and practice in the United Kingdom. Recent efforts have been made at developing conceptual models of public health in an effort to clarify the concept. The most notable and appropriate for this study was developed by Griffiths *et al.* (2005). The framework has three inter-related domains of ‘*health prevention, health improvement*’, and ‘*health service delivery and quality*’. In the context of this study; health prevention and health promotion relate to *roles* (subsidiary question *b*); and health service delivery and quality relate to *policy implementation* (subsidiary question *a*). Adopting this framework was useful in adopting Winslow’s (Winslow 1920), and Acheson’s (Acheson 1988)



definitions of public health for this study. What is not disputed in the literature is that public health refers to the health of identified populations (WHO 1986). The contention regarding defining public health was partly explained by Rosen's observations that health is inter-connected with social life (Rosen 1993).

#### 1.2.2 According to Winslow,

*'Public health is the science and the art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventative treatment of disease, and the development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health'* (Winslow 1920, p.23).

This approach to public health highlights the importance of public health roles, including those of community learning disability nurses.

#### 1.2.3 The Acheson Report has described public health as,

*'....the science and art of preventing disease, prolonging life and promoting health through organised efforts of society'* (Acheson 1988, p.27).

#### 1.2.4 The UK public health policy adopts the Acheson (Acheson 1988) definition (Chief Medical Officer 2007). Another notable influence on our understanding

of the meaning of UK public health, and its relevance to this study is the Faculty of Public Health. The Faculty of Public Health (FPH) is the standard setting body for professionals, and specialists in public health in the UK. The FPH organises public health practice into 3 domains (health improvement, health protection, and improving services) (Faculty of Public Health 2012). These domains are similar to Griffiths *et al.*'s model (Griffiths *et al.* 2005). In addition to the 3 domains, the FPH identifies 9 key areas of public health practice and these are given in *Box 1a* below.

*Box 1a: Key areas of public health practice (Faculty of Public Health 2012).*

1. Surveillance and assessment of the population's health and wellbeing.
2. Assessing the evidence of effectiveness of health and healthcare interventions, programmes and services.
3. Policy and strategy development and implementation.
4. Strategic leadership and collaboration for health.
5. Health improvement.
6. Health protection.
7. Health and social service quality.
8. Public health intelligence.
9. Academic public health.

1.2.5 Griffiths *et al.*'s model (Griffiths *et al.* 2005), the FPH's domains of public health, and the 9 key areas of public health practice influenced this study in the formulation of research questions, formulation of *a priori* theoretical categories in stage 1, formulation of semi-structured interviews in stage 2, and formulation of survey questions in the explanatory phase of the study.

1.2.6 In order to identify what constitutes '*public health policy*' for the purpose of this study, the definitions of what is '*public*', what is '*health*', and what is '*policy*' needed to be clarified. There is very little agreement on how to define '*policy*' (Ham and Hill 1984; Davis 1993; Torjman 2005). Predominantly there are two broad views that emerge from literature. The classical view, which looks at public policy as an object or product (Colebatch 1998), and the interactional position (Colebatch 1998; Stone 1988), which looks at policy as a complex process and interaction between policy makers, policy implementers, and policy recipients. The classical view was particularly important in stage 1, and the interactional position was relevant for stages 2, and 3 of this study. Dye (1972) has defined public policy as any action a government chooses to do or not to do. Bridgman and Davis (1998) describe a complex 6-stage model (problem recognition; identification of possible solutions; choice of best solution; policy implementation; policy evaluation, and policy termination) of the policy making process which was relevant in contextualising this study. My understanding of this model was useful in locating the public health policy implementation involvement of community learning disability nurses within the wider policy context. This study adopted Dye's definition described above. What the UK government chooses to do regarding public health for people with learning disabilities is perhaps reflective of the complexity of both the classical, and interactional views of public health policy in the UK.

1.2.7 This study took place in the four countries of the UK, and as such an understanding of the public health policy landscape across the four countries was important from the inception up to the writing up of this thesis. The public health policy picture in the United Kingdom can best be described as

uncoordinated. Each of the four countries of the United Kingdom has different policies, and this divergence has been increasing since devolution (Greer 2009).

1.2.8 In England, *Choosing health* (DH 2004a) identified six key priority areas for public health (reducing the numbers of people who smoke; reducing obesity and improving diet and nutrition; increasing exercise; encouraging and supporting sensible drinking; improving sexual health; and improving mental health). Since then a series of other public health policy initiatives have been adopted including, *Delivering choosing health* (DH 2005b); *Our health Our care Our say* (DH 2006a); *Health challenge England* (DH 2006b); *Tackling health inequalities* (DH 2007a), and more recently, *Healthy lives Healthy people* (DH 2010).

1.2.9 Since devolution there has been a distinct public health approach in Scotland (Greer 2009; Donnelly 2007). Prior to devolution, *Scotland's health: A challenge to us all* (Scottish Office 1992) identified coronary heart disease, and cancer as key public health targets. Since then a series of other policies have emerged and include, *Our national health: A plan for action A plan for change* (Scottish Executive 2000a), *Improving health in Scotland* (Scottish Executive 2003), *Better health Better care: Action plan* (Scottish Government 2007), *Equally well* (Scottish Government 2008). Like in England, none of these policies specifically addressed the public health needs of people with learning disabilities.

1.2.10 Northern Ireland has adopted a much more focused, and sustained public health policy approach (Wilde 2007; NI Executive 2008). Since the 1990s key policy documents have emerged and include, *Health and wellbeing: Towards the new millennium* (DHSSNI 1996), *Well in 2000* (DHSSNI 1997), *Investing for health* (DHSSPSNI 2002) and *A healthier future* (DHSSPS 2004). Recent work led by the Public Health Agency has strengthened this position for people with learning disabilities (Public Health Agency 2011; Slevin *et al.* 2011).

1.2.11 Wales was the first UK country to develop a comprehensive and inclusive public health strategy (Welsh Office NHS Directorate 1989; 1992), which was quite distinct (Greer 2009; Coyle 2007). The identified priority areas were, cancer, maternal and child health, emotional health, respiratory illness, cardiovascular diseases, learning disability, mental distress and illness, injuries, healthy environments, and physical disabilities. Since then a series of other public health policy initiatives emerged and include, *Better health Better Wales* (Welsh Office 1998), *Improving health in Wales* (NAfW 2001), *Wellbeing in Wales* (Welsh Assembly Government 2002), *Wales – A better country* (Welsh Assembly Government 2003), and *Designed for life* (Welsh Assembly Government 2005).

1.2.12 In 2004 the UK-wide GP contract was renegotiated (Aswani 2007), and it specified three distinct groups of services, essential services (compulsory - consultations), additional services (optional – immunisation and screening), and enhanced services (optional – specialised services). There were originally 10 indicators on the *Quality outcomes framework* (QOF), and this has been

repeatedly revised, and has included learning disabilities since 2006. What is important to note in relation to this study is the optional nature of the approach to key public health policy delivery at the primary care level. This is likely to have an impact on how community learning disability nurses enact their public health roles in implementing public health policy for people with learning disabilities. In 2008 additional payment for the provision of *Clinical directed enhanced services* (DES) for people with learning disabilities was introduced. This was intended to improve access to generic public health services by people with learning disabilities at the primary healthcare level. In turn this policy initiative is likely to have had an impact on how community learning disability nurses enact their public health roles.

1.2.13 The approach to public health policy in the UK, outlined here, can best be described as unco-ordinated. What is not clear from existing studies is what roles community learning disability nurses play in implementing these policies, how they interpret and enact those roles, and what moderates how they enact those roles. This study sought to find some answers to these questions.

1.2.14 In addition to the public health policies discussed here, specific policies, which aim to address the public health, needs of people with learning disabilities exist. It is therefore important at this point to explore some of these policy initiatives and highlight their relevance to this study.

### **1.3 Learning disability policy**

1.3.1 The policy agenda for the provision of healthcare for people with learning disabilities in the UK can be traced back to the beginning of the twentieth

century. In England, the 1913 *Mental Deficiency Act* provided a distinct legal identity for people with learning disabilities. The operational segregation of service provision for people with learning disabilities provided for in the Act has had a long and lasting effect. Remnant effects are still evident today, and may influence how community learning disability nurses enact their public health roles. Under the Act, service provision for people with learning disabilities was based in large hospitals, which were under the remit of psychiatry.

1.3.2 Negative reports regarding segregated service provision (Department of Health and Social Security 1969; Morris 1969) led to a new policy direction through *Better services for the mentally handicapped* (Department of Health and Social Security 1971). This policy shift had two significant effects in relation to this study. The first effect was the shift of service provision from institutions to the community. The second effect was that learning disability nurses had to re-align their roles with the new models of service provision. As de-institutionalisation gathered pace in the 1980s and 1990s, policies focusing on meeting the public health needs of people with learning disabilities in the community began to emerge.

1.3.3 *Health services for people with learning disabilities (mental handicap)* (NHS Executive 1992a) highlighted the need for people with learning disabilities to access generic healthcare services. However, this policy acknowledged the need for specialist health, and healthcare provision where appropriate. It could be argued that this position contributed to the development of some community learning disability public health nursing roles. *The health of the*

*nation* (DH 1992) identified five key public health areas for England (coronary heart disease and stroke, cancer, HIV/AIDS and sexual health, accidents, and mental illness). A specific '*Health of the nation strategy*' for people with learning disabilities was published in 1995 (DH 1995), and focused on the five key public health areas.

1.3.4 *Signposts for success* (NHS Executive 1998) outlined care pathways for people with learning disabilities in mainstream services. This was an acknowledgement that people with learning disabilities were experiencing poor access to services in the NHS. The emphasis was on ensuring that people with learning disabilities' healthcare needs were met through mainstream services. However, the policy document recognized the need for continued specialist health, and healthcare provision in areas such as mental health, epilepsy, and complex needs.

1.3.5 Another important policy development was *Once a day* (NHS Executive 1999). This policy highlighted the challenges people with learning disabilities faced in accessing health services. The policy also provided guidance for primary healthcare teams on how supports could be provided to people with learning disabilities in order for them to access health promotion, and health screening services through primary care services.

1.3.6 Chapter 6 of *Valuing people: A new strategy for learning disability for the 21<sup>st</sup> century* (DH 2001) highlighted the need to improve the health of people with learning disabilities in England and Wales (*The same as you* in Scotland) (Scottish Executive 2000b). The complexity of the healthcare needs of people



with learning disabilities are acknowledged, and the inadequacies of existing models of healthcare provision for people with learning disabilities in generic healthcare settings highlighted. In Scotland, the *Health needs assessment report: People with learning disabilities in Scotland* (NHS Health Scotland 2004) highlighted the needs of people with learning disabilities and provided guidance to healthcare professionals on how these could be met.

1.3.7 A number of initiatives relevant to policy implementation, and public health roles of learning disability nurses were proposed in *Valuing people* (DH 2001). In order to improve the implementation of public health policy initiatives, and access to services for people with learning disabilities, health action planning was introduced (DH 2002; DH 2009a). Health facilitation and health liaison were also introduced (DH 2001). These policy initiatives had a significant effect on the public health roles of community learning disability nurses.

1.3.8 Since *Valuing people* was published in 2001 (DH 2001), there have been other notable developments, which have affected the implementation of public health policy for people with learning disabilities, and the public health roles of learning disability nurses. Although these are not discussed at this point in any detail, they are worth noting in order to broaden the context of this present study. These notable developments include, *Treat me right* report (Mencap 2004) which highlighted the health needs of people with learning disabilities and suggested how access to services could be improved. *Equal treatment: Closing the gap* (DRC 2006) revealed an inadequate response from the NHS, and the English and Welsh governments to the major physical health inequalities experienced by people with mental health needs and,

people with learning disabilities. *Death by indifference* (Mencap 2007) alleged institutional discrimination within the NHS, which resulted in people with a learning disabilities receiving ineffective healthcare. The report presented the stories of six people who the authors believed had died unnecessarily as a result of healthcare professionals' lack of understanding of the complexity of the healthcare needs of people with learning disabilities. *Healthcare for all* (Michael 2008) highlighted the high levels of unmet health needs of people with learning disabilities, and poor access to services, and ineffectiveness of the treatment they received. *Valuing people now* (DH 2009b) outlined the English government's response to the *Healthcare for all report* (Michael 2008). *Six lives* (Parliamentary and Health Service Ombudsman and Social Services Ombudsman 2009) was the government's response to *Death by indifference* (Mencap 2007).

1.3.9 The policies and recommendations in documents identified here are noble, and well meaning. However, it is important to note that most of these reports, and policies only provided 'frameworks' for action. The visions set out in these documents, and recommendations were visionary, ambitious, and in some cases comprehensive. However, no resources were provided for their implementation for people with learning disabilities. Mansell (2008) has observed that the implementation of these 'soft' policies was more likely to be opportunistic, and *ad hoc* and resulted in a '*post code*' approach to national health policy implementation for people with learning disabilities.

1.3.10 Arguably these policies have in some way sought to address the public health needs of people with learning disabilities. Nonetheless it is also clear that

there is a lack of clarity at organisational, and professional level is to where responsibility lies for their implementation. This was quite important in how I formulated interview questions in stage 2, and how I formulated the survey questionnaire in stage 3. The consequences of this lack of clarity on how community learning disability nurses are involved in the implementation of these initiatives need to be addressed. How these policies are cascaded into community learning disability nurses' job descriptions, and other role descriptors across the UK is what stage 1 of this study sought to answer.

1.3.11 The lack of organisational and professional role clarity for the implementation of public health policy for people with learning disabilities is rather surprising at the least, given the extent of the health, and healthcare needs of people with learning disabilities. An exploration of literature relating to the extent of the health, and healthcare needs of people with learning disabilities is appropriate at this point in order to contextualise the study.

#### **1.4 Health needs of people with learning disabilities**

1.4.1 There is a disparity between the health, and the healthcare needs of people with learning disabilities as compared to that of the general population (Kerr 2004; DH 2001). According to *van Schroyen Lantman-de Valk et al.* (2007), these disparities in health and health outcomes are avoidable. They could be improved through appropriate interventions (Oullette-Kuntz 2005). Whitehead (1992) has noted that for people with learning disabilities, these disparities resulted from poor access to health services, limited options in lifestyle, and poor living standards. It could be argued that facilitating access to services is an important public health role for community learning disability

nurses. Investigating how community learning disability nurses enact this role would be important in understanding their contribution to public health policy implementation for people with learning disabilities.

1.4.2 People with learning disabilities are known to have much greater health needs than those of comparable age groups who do not have learning disabilities (NHS Executive 1998; DH 1999b; Cancer Research UK 2008; Backer *et al.* 2009). For example, people with learning disabilities experience higher rates of mental disorders as compared to the general population (Wilson and Hare 1990; Linna *et al.* 1999). Moreover, existing studies show that these health problems are commonly, and widely undiagnosed, misdiagnosed, and untreated (Wilson and Hare 1990; Bailey and Cooper 1997). In addition, people with learning disabilities experience higher rates of visual impairments (Beange *et al.* 1995; Barr *et al.* 1999); epilepsy (Ryan and Sunada 1997; McDermott *et al.* 1997; Whitfield *et al.* 1996); hypertension and hypothyroidism (Barr *et al.* 1999); and, obesity (*van Schroyen Stein Lantman-de Valk et al.* 2000). Furthermore, people with learning disabilities are more likely to die from preventable causes (Hollins and Sinason 1998; Mencap 2007; DH 2007a; DH 2007b; Durvasula *et al.* 2002; Nissen and Havemann 1997; Pawar and Akuffo 2008; *van Schroyen Stein Lantman-de Valk et al.* 2000). Although the life expectancy of people with learning disabilities has increased with that of the general population (McLoughlin 1988), overall life expectancy still remains lower, and mortality rates remain significantly higher than those of the general population (Durvasula *et al.* 2002; Hollins and Sinason 1998). What is perhaps important in the context of public health is an understanding of the risk factors in order to prevent premature deaths

(Durvasula *et al.* 2002). The literature explored here suggest that there is a need for research that evaluates how community learning disability nurses enact their surveillance roles in identifying the complex health, and healthcare needs of people with learning disabilities.

1.4.3 People with learning disabilities experience health inequalities (Scheepers *et al.* 2005; Melville *et al.* 2006), and poor access to healthcare (DH 1999b; DH 2001; NPSA 2004; Mencap 2004; DRC 2006; Whitehead 1992; Nocon *et al.* 2008; Brown *et al.* 2010). Studies have shown that people with learning disabilities are considered a low priority by healthcare professionals (Aspray *et al.* 1999). International studies have demonstrated widespread concerns about the inequalities in health for people with learning disabilities (Janicki 2001; Scheepers *et al.* 2005; WHO 2003). Evidence suggests that these disparities in health, and health outcomes for people with learning disabilities have been attributed to service users, health organisations, and health service systems. Straetmans *et al.* (2007) identified communication difficulties and limited understanding of the diagnostic, and treatment issues for people with learning disabilities. In addition, Lennox and Diggins (1999) have noted that healthcare professionals have limited augmentative communication skills, which further limits their ability to diagnose, and treat people with learning disabilities appropriately. People with learning disabilities have complex health needs, and comorbidity is common. Messent *et al.* (1999) identified life-style related comorbidity as a significant contributory factor to disparities in health for people with learning disabilities. In addition, Jones and Kerr (1997) have noted that cognitive impairments limit people with learning disabilities' ability to access public health initiatives.

1.4.4 People with learning disabilities experience unequal access to health services (Kerr 2004; DRC 2006; Iacono and Davis 2003; Janicki *et al.* 2002; Scheepers *et al.* 2005; Mencap 2004). People with learning disabilities experience inadequate diagnosis of treatable conditions (Hollins *et al.* 1998; Mencap 2007; DH 2007a; DH 2007b; Durvasula *et al.* 2002). In the UK, access to public health is primarily through the primary healthcare system. Current literature show that a significant proportion of health inequalities in people with learning disabilities are linked to poor quality healthcare provision (Michael 2008; Mencap 2012; Parliamentary Health Ombudsman and Social Services Ombudsman 2009). This rather suggests that these inequalities are preventable. The UK government policy has focused on improving people with learning disabilities' access to generic, and preventative health services for some considerable time (DH 1992; DH 1995; NHS Executive 1998; DH 2001; DH 2009b; Ruddick 2005). However, the continuing disparities in health in people with learning disabilities suggest that policies alone are not enough. What is important and what this study sought to understand was how community learning disability nurses mediated public health policy implementation (Thornton 1996) for people with learning disabilities.

1.4.5 Barriers to accessing services contribute to health inequalities. A significant number of barriers that contribute to failure in meeting the healthcare needs of people with learning disabilities have been identified (Melville *et al.* 2006; Lennox *et al.* 1997; Mencap 1998; Barr *et al.* 1999; Bollard 1999; Webb and Rogers 1999; Curtice *et al.* 2001; NHS Health Scotland 2004). Lack of role clarity of the professionals working with people with learning disabilities has been consistently identified as one of the most common barrier (Thornton

1996; Powrie 2003; NHS Health Scotland 2004; Phillips *et al.* 2004; Melville *et al.* 2005). The importance of primary healthcare services in meeting the health needs of people with learning disabilities has been highlighted (Lennox and Kerr 1997; Phillips *et al.* 2004). However, there appear to be a lack of evidence as to the role of community learning disability nurses in addressing barriers experienced by people with learning disabilities when accessing generic public health services.

- 1.4.6 International studies have shown poor uptake of public health initiatives in the population of people with learning disabilities (Beange *et al.* 1995; Beange and Bauman 1990; Jacobson *et al.* 1989; Kerr *et al.* 1996; Stein and Allen 1999; Jones and Kerr 1997; Sullivan *et al.* 2003; Wood and Douglas 2007). Other studies have shown that people with learning disabilities have reduced access to health screening, and health promotion services (Kerr *et al.* 1996; Whitfield *et al.* 1996). Lennox *et al.* (2000) have noted the need for effective health advocacy from relevant health professionals. Kerr *et al.* (2003) have observed that healthcare outcomes are dependent on individuals' ability to seek appropriate care. This however cannot be taken for granted with the population of people with learning disabilities. Codling and Macdonald (2011) have pointed to a lack of evidence that show the involvement of people with learning disabilities in addressing their healthcare needs. This situation suggests that people with learning disabilities are passive participants in their health and healthcare, and that they are dependent on others for their health and healthcare outcomes (Robertson *et al.* 2001; Campbell and Martin 2009; Keywood *et al.* 1999). In the past few decades efforts to depathologise learning disabilities have gathered pace, resulting in people with learning

disabilities having to access generic health services. Recently in the UK, there has been a shift from healthcare treatment to preventative healthcare (NHS Executive 1994; Adams *et al.* 2001; NHS Breast Screening Programme 2006). However, studies which address the public health needs of people with learning disabilities are limited (Hogan *et al.* 2000; Steele *et al.* 1996). A limited number of studies, which scrutinised access to health promotion activities by people with learning disabilities exist (Messent *et al.* 1999; Beart *et al.* 2001). Thomas and Kerr (2011) have concluded that delivering effective public health initiatives for people with learning disabilities is challenging. What is more concerning, and perhaps more important for this study is the observation made by McIlfatrick *et al.* (2011) that the provision of public health services for people with learning disabilities was opportunistic, despite evidence that point to a need for targeted activities (Chauhan *et al.* 2010). Felce *et al.* (2008) have suggested that in the absence of people with learning disabilities' ability to self refer for healthcare; it was logical that provision of health services for this population be proactive rather than reactive. Existing studies have demonstrated that preventative interventions such as health screening are effective in identifying the health needs of people with learning disabilities in the UK (Martin *et al.* 1997; Baxter *et al.* 2006; Cooper *et al.* 2006; Emerson and Glover 2010; Emerson *et al.* 2011); in Australia (Beange *et al.* 1995); and in New Zealand (Webb and Rogers 1999). Lennox *et al.* (2000) have argued that the opportunistic approach to preventative health for people with learning disabilities was not adequate in order to meet the healthcare needs of this population. Although in the UK the introduction of the QOF in 2004, and the later introduction of DES in England (*Scottish enhanced services programme* (SESP) in Scotland), which placed the responsibility of



preventative health service provision for people with learning disabilities on GPs; there has been a longstanding debate as to whether this role belongs to primary care or to the community team for people with learning disabilities (Matthews and Hegarty 1997; Curtice and Long 2002). What was not clear from these studies, and which needed investigating was the role played by community learning disability nurses in preventative interventions for people with learning disabilities.

1.4.7 Reviewing literature relating to the extent of the health, and healthcare needs of people with learning disabilities was particularly important in how data analysis was approached in stage 1 of the study. It was important to clarify the roles of community learning disability nurses in implementing public health policy for people with learning disabilities in the context of the extent of their health, and healthcare needs. The lack of organisational and professional clarity as for the responsibility of public health policy implementation has been noted earlier in this chapter. Given this lack of clarity, it is prudent at this point to explore approaches to public health policy implementation in the UK. This is important in order to locate learning disability nurses' public health policy implementation roles within the UK public health policy process.

## **1.5 Public health policy implementation and people with learning disabilities in the UK**

1.5.1 Being a novice researcher I needed to understand the UK policy process in order to understand the public health policy implementation process, which was central to this study. Examination of literature on the policy-making

process revealed that a number of models are available (Fafard 2008). Of these models, '*the stages model*' which can be traced back to the work of Lerner and Lasswell (1951) is the most widely used, and on the other hand the most criticised (Fafard 2008). Since then various modifications to this model have been put forward (Jones 1977; Howlett and Ramesh 2003). This model was useful for this study because it assumes that policy making is based on logic and evidence, and is supposed to focus on problem solving. Despite its limitations and criticisms (Marmot 2004; Burton 2006), '*the stages model*' is widely acknowledged in literature as the most heuristic (Deleon 1999; Burton 2006) approach in policy studies and in policymaking. In the original model put forward by Lerner and Lasswell (1951) there are seven stages from intelligence to evaluation. Variants of this model aimed at improving the original model have been developed, and of interest to this study was the 5-stages model (Howlett and Ramesh 2003) (see *Table 1a*).

*Table 1a:* The stages model in the policy cycle (Howlett and Ramesh 2003)

Stage	Activity
1	Agenda setting
2	Policy formulation
3	Decision-making
4	Policy implementation
5	Policy evaluation

All the five stages in the model were important to this present study. However, the main aim of the study was to investigate community learning disability nurses' involvement with public health policy implementation for people with learning disabilities, and therefore only the implementation stage (4) is further

explored in detail here. Fafard (2008) has suggested that the implementation stage requires an evidence base because;

*‘...it is precisely at the policy implementation phase where broad policy is translated into detailed programme choices’* (p. 12).

Furthermore, Davis and Mannion (2000) have pointed out that this stage requires collaboration between policy formulators and policy implementers, and it is important to know what approaches to policy implementation are effective.

1.5.2 Appropriate and relevant literature on *‘implementation’* can be traced back to Pressman and Wildavsky (1973). According to Linder and Peters (1987), *‘implementation’* has become a *‘social science’*. Crinson (2009) noted the ambiguity and complexity of the concept of policy implementation. The source of this ambiguity seems to arise from the dialogical definition of the term itself in that it refers to both process and outcome.

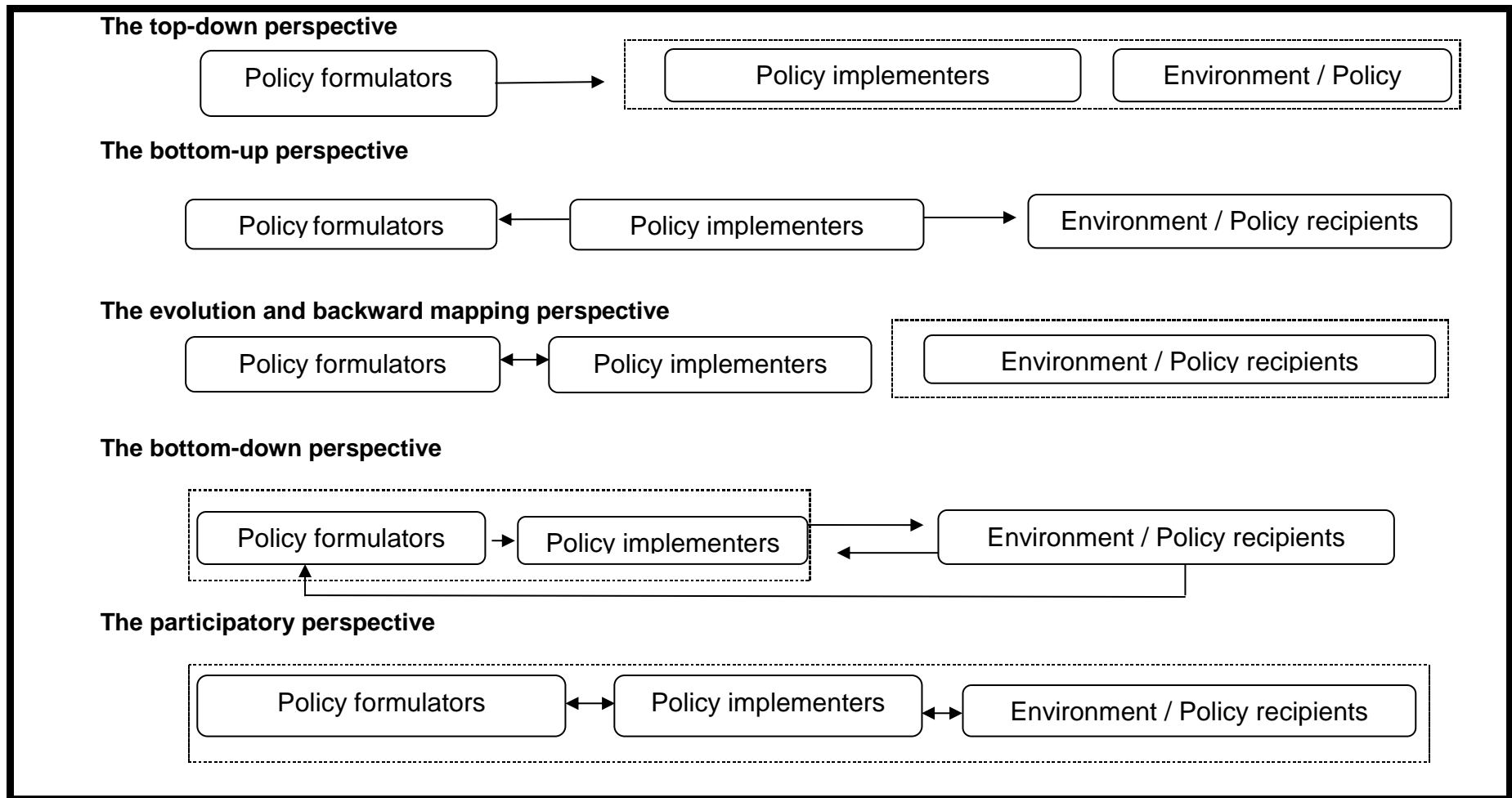
1.5.3 In essence, policy implementation does not necessarily relate to the successful achievement of the original objectives intended by the policy makers (Lane 2000; Crinson 2009). Approaching policy implementation from a procedural perspective arguably leads to deficits in policy outcomes (Crinson 2009). The realisation of disconnects between policy objectives and policy outcomes have been the subject of many studies (Simon 1947; Hood 1976; Hogwood and Gunn 1984; Rutten *et al.* 2010; Tataw 2010). In the literature examined there were broadly two groups of these studies. These led to the development of a number of policy implementation philosophical frameworks, and methodological models that are relevant to our

understanding of the involvement of community learning disabilities in the implementation of public health policies for people with learning disabilities.

1.5.4 The first group of literature focuses on frameworks and models for perfect policy implementation (Simon 1947; Hood 1976; Hogwood and Gunn 1984; Rutten *et al.* 2010; Tataw 2010). These studies predominantly focused on strategies to avoid policy implementation failure. The importance of these studies to this present study was that they implied that the majority of failures in policy are a result of failures in implementation. In addition to this view, Hogwood and Peters (1985) have argued that some policy failures were due to policy design. Furthermore, Sieber (1981) has observed that some policies could create more unwanted effects than the original goals. However Mayntz (1983) has argued that concluding that policy failure was just a direct consequence of implementation failure was insufficient.

1.5.5 The second group of studies has focussed on developing the philosophy and theory of policy implementation. Historically, there are five major schools of thought regarding policy implementation theory (See *Figure 1c*). All these frameworks influence the outcomes of how policy is implemented and are therefore important in our understanding of community learning disability nurses' involvement with public health policy implementation. It was therefore important to have a clear understanding of these frameworks at all stages of this study.

Figure 1a: Perspectives of policy implementation – summaries (adapted from Linder and Peters (1987), and Tataw (2010)).



1.5.6 The first approach is the '*top-down*' (bureaucratic) perspective to policy implementation, which is inherent in bureaucratic systems such as the NHS. According to Dunsire (1978) this approach takes the view that policy implementation has to be enforced through the management structures of organisations. Sabatier and Mazmanian (1979) have developed a model, which identified clarity of the policy statement itself; proposed implementation structures; managerial and political skills of policy implementers; and commitment of implementers to policy goals as key variables. Hogwood and Gunn (1984) have identified 10 pre-conditions necessary for effective policy implementation. These include sufficient time and resources; rationale for the policy and implementation strategy; an understanding of the policy objectives; identified implementing organisation with appropriate authority; and effective communication structures between policy formulators and policy implementers. Hill (1997) has criticised this model as utopian and simplistic. Another criticism of this model includes accusation of a lack of focus on organisational moderators of policy implementation outcomes (St Leger 1998). Thomas *et al.* (1998) have criticised the model as an unrealistic '*perfect*' implementation model.

1.5.7 Overall bureaucratic policy implementation models are criticised for a variety of assumptions they supposedly make. Crisnson (2009) has criticised the models for over-simplifying the complex phenomenon of the policy implementation process. Hill (2004) has noted that the bureaucratic models ignore the fact that policy implementation occur in an environment of conflicts of interest, negotiation, and compromise. Another criticism put forward by Hill (2004) is that the models suggest that there is a clear distinction of the policy

making process, and the policy implementation process. In reality the boundaries between the processes are at best blurred and difficult to identify. Community learning disability nurses work in bureaucratic organisations, and understanding how they enact their public health roles in such organisations was an important element of this study.

1.5.8 The second approach is the '*bottom-up*' (democratic) perspective. The main assumption of this perspective is that policy implementation has to be negotiated between policy implementers and policy recipients at the '*street level*' (Lipsky 1980). One notable model that appears in literature is that put forward by Elmore (1980). This model focuses on the role played by policy implementers rather than on organisational structures. Elmore (1980) has argued that in reality policy implementers on the '*shop floor*' often have to work in an environment full of conflicting policy initiatives. Bottom-up models contend that for successful policy implementation, policy implementers need various degrees of operational freedom in order to manage uncertainties that are normally associated with new policies (Crimson 2009). The essence of this approach is that policy implementation is better decentralised without any element of central control (Hogwood and Gunn 1984). According to Lane (1983), a major weakness of this approach is the potential differences in the understanding of policy intentions between policy makers, policy implementers, and policy recipients. This was of significance to this current study given the '*localisation*' of public health policy implementation for people with learning disabilities in the UK.

1.5.9 According to Lane (2000), bureaucratic models focus on organisational structures, planning and control, whilst the democratic models advocate that for effective policy implementation; flexibility, responsiveness, and problem solving are essential. However, it is clear that the complexity of policy formulation and implementation means that neither the bureaucratic nor the democratic approaches would be sufficient on their own (Crinson 2009). UK public health policies range from the very simple, single-aimed policy directives to the very complex. Many recent reports have highlighted how health policy implementation deficits affect healthcare delivery to people with learning disabilities (DRC 2006; Mencap 2007; Michael 2008; Parliamentary Health Ombudsman and Social Services Ombudsman 2009). In the UK, implementation of health policy is supposedly driven by local needs. Understanding how community learning disability nurses enact their public health roles in this '*local approach*' to public health policy implementation was an important element of this study.

1.5.10 The third approach to explaining policy implementation is the '*evolution and backward mapping*' perspective put forward by Pressman and Wildavsky (1973), and further developed by Majone and Wildavsky (1978). The main view of backward mapping is that policy evolves during implementation as a result of interactions between policy implementers and policy recipients. The evolutionary position of this approach argues that what is negotiated and implemented becomes policy. How community learning disability nurses as policy implementers understand, negotiate, and implement public health policy for people with learning disabilities was therefore also of significance in this study.



1.5.11 The fourth perspective is the '*from the bottom down*' (Mazmanian and Sabitier 1983). This was developed from the top-down approach. Although the approach focuses on centrally driven policy implementation, it highlights the importance of effectiveness and evaluation. The essence of this approach is structured delegation. This perspective was important to this study for a number of reasons. McDonnell *et al.* (2006) have pointed out that UK health policy is usually implemented and changed without evaluation. They noted that this has led to difficulties in conducting reliable studies on how policy is implemented and evaluated. Greenhalgh *et al.* (2004) have identified the need for action as articulated by opinion leaders in healthcare as having priority over effective and successful policy implementation.

1.5.12 Recent growing calls for consumer voice in public health and health promotion (Lee and Garvin 2003) has led to a '*horizontal participatory*' perspective to policy implementation being put forward (Tataw 2010) (see *Figure 1a* and *Table 1b*). The approach focuses on the participation of policy recipients in policy planning, formulation, implementation, and implementation evaluation (WHO 2003). It is argued that the essence of this model is that for public health policies to be effective, policy recipients need to be meaningfully involved at every level in the policy process (Kretzman and McKnight 1993). In this approach the role of policy implementers such as community learning disability nurses become more facilitatory. According to Penner (1994), the participatory approach to health policy implementation facilitates inter-agency working. The approach has a number of attributes, and five of these were pertinent to this study (See *Table 1b*). Firstly, policy implementers such as community learning disability nurses need to have a central role in policy

formulation. In addition, policy implementers need to have a high degree of autonomy and flexibility on how policy is implemented. Furthermore, in this approach, community learning disability nurses as policy implementers would play a key role in policy implementation. The fourth attribute is that structural relationships are horizontal. In the relationships; professionals and organisations involved interact at the same level. Finally, the approach suggests that boundaries in the policy process only exist at the conceptual level (Tataw 2010; Tataw *et al.* 2007). This was important for this study given the inter-agency approach to the public health policy process in the UK, which ultimately is likely to have significant impact on how community learning disability nurses enact their public health roles.

Table 1b: Perspectives of policy implementation - comparisons (Adapted from Linder and Peters (1987) and Tataw (2010)).

<b>Criteria</b>	<b>Top-Down</b>	<b>Bottom-Up</b>	<b>Bottom-Down</b>	<b>Evolution / Backward Mapping</b>	<b>Participatory</b>
<b>Attitudes of implementation setting towards target</b>	Sympathetic implementation agency	Implementers adopt policy to local context	Sympathetic implementation agency (with legal mandates)	Implementers adopt policy to policy recipients' needs	Sympathetic implementers who are also formulators
<b>Structural relationships</b>	Structurally and culturally vertical	Structurally and culturally vertical	Structurally and culturally vertical	Structurally vertical, culturally horizontal	Structurally and culturally horizontal
<b>Flexibility in adjusting policy</b>	Limited implementers autonomy	High implementers autonomy and flexibility	Limited implementers autonomy	High implementers autonomy and flexibility	High implementers autonomy and flexibility
<b>Boundary fluidity</b>	Tight boundaries between settings	Tight boundaries between settings	Tight boundaries between settings	Tight boundaries between settings	High boundary fluidity
<b>Role of implementers in policy formulation</b>	Limited role	Limited role	Limited role	Limited role	Implementer has central role in policy formulation

It is clear that all the perspectives discussed here have their limitations. The absence of an all-encompassing theory of policy implementation makes the process of public health policy implementation difficult (Mafuba 2012b). What is important however is that all these perspectives highlight the importance of understanding the causes and failures of policy implementation. Furthermore, for the purposes of this study all the perspectives emphasise the importance of the roles played by policy makers, policy implementers, and policy recipients in the success or failure of policy implementation.

1.5.13 There are very few studies, which have evaluated the effectiveness of health policy implementation for people with learning disabilities. Some authors have noted that the evaluation of health policy implementation has been neglected (Hill 2003; O'Toole 2004). Northway *et al.* (2007) have pointed out that translating policy frameworks into operational policies for people with learning disabilities is complex. In addition, policy effectiveness is dependent on implementation (Barrett 2004), and staff involved (Northway *et al.* 2007; Lipsky 1980). Policy effectiveness is likely to impact on how implementers such as community learning disability nurses enact their public health roles. Research on how policy is implemented, and its impact on professional roles is therefore of significance (Fyson 2002).

1.5.14 Fyson (2002) has investigated the relationship between health and social services, and the factors, which affect health and social policy implementation for people with learning disabilities. The study investigated why health and social care policies for people with learning disabilities are difficult to implement, and why there is such a disparity between policy and practice.

The study was extensive and involved semi-structured interviews with staff at all levels in learning disability services. What was of interest to this current study among the findings by Fyson (2002) is the worrying extent of the local variations in interpretation of national policy frameworks. Understanding how these variations impacted on how community learning disability nurses interpreted national public health policy and enacted their public health roles was an important part of this present study.

1.5.15 Lin *et al.* (2004) have examined how healthcare policies were implemented for people with learning disabilities in Taiwan. The study identified a number of issues that affected the implementation of health policies for people with learning disabilities, which I considered to be relevant to this current study. The study observed that poor access to preventative health, lack of resources, and lack of coordination in the implementation of health policies negatively impacted on the effective implementation of health policies for people with learning disabilities. In addition, and perhaps a finding of greater significance for this current study was the negative effect of a lack of role clarity and professional conflicts regarding the implementation of health policy for people with learning disabilities.

## 1.6 **Conclusion**

1.6.1 This review of literature has demonstrated the extent, and complexity of the health and healthcare needs of people with learning disabilities. Research evidence demonstrate that despite high levels of preventable conditions, people with learning disabilities experience poor access to health and healthcare services including public health services.

1.6.2 It is clear that the UK public health policy agenda is complex, disparate, and fragmented. Current approaches to healthcare and public health policy delivery in the UK are failing to meet the health needs of people with learning disabilities. Exploring the roles of community learning disability nurses in how public health policy is implemented for people with learning disabilities is important in order to improve their health, and their health outcomes. Understanding how community learning disability nurses enact their public health roles in implementing public health policy for people with learning disabilities is also important. In order to contextualise how community learning disability nurses enact their public health roles it is important to explore the literature pertinent to role theory and its role in our understanding of nursing practice in the next chapter of this thesis.

## **Chapter 2: The Nature of Role Theory and Application to Nursing**

### **Introduction**

This chapter commences with the exploration of the origins of role theory. This is followed by an analysis of cognitive and organisational role theories. The third section in this chapter explores role ambiguity and its impact on role enactment. Literature relating to developments of role theory in nursing is then explored. Finally, a detailed discussion of the importance of job descriptions, and person specifications in how learning disability nurses enact their roles is undertaken.

### **2.1 The origins of role theory**

2.1.1 The word '*role*' and its use originated in the French language, and was originally derived from the Latin word '*rotula*', which meant a round log on which leaves were fastened and rolled into scrolls (Thomas and Biddle 1966a). In England, this term subsequently referred to any official documents or '*rolls*'. The use of the word '*role*' began in theatres between the sixteenth and seventeenth centuries when scenic parts for actors were read from '*roles*' (Moreno 1953, 1960a). It is not clear when and where the use of the word '*role*' as a description of a set of connected behaviours, rights, and obligations in the interactionist and functionalist conception of society began. The definition of role in the context of this study is further discussed later in this chapter.

2.1.2 It is ambiguous as to when and where the use of the word '*role*' as a concept originated prior to the development of '*role theory*'. Clarity of the use of the word '*role*' as in role theory in literature can be traced back to significant pioneer role theorists during the first half of the twentieth century (Mead 1934; Moreno 1934, 1953; Linton 1936; Cottrell 1933; Sherif 1936; Hughes 1937; Parsons 1937; Sarbin 1943; Newcomb 1942). All these theorists made significant contributions to the development of role theory. However, only the works of Mead (1934), Moreno (1934, 1953) and Linton (1936) are explored here because of their significance to this current study. Before this exploration takes place, it is important to adopt a definition of '*role*' for the purpose of this study. Banton (1965) described a role as a position occupied by an individual. This definition implies that role can only be understood as a social process involving interactions and expectations of an individual, and their role set (Merton 1957). In the context of public health policy in the UK, role sets can be uni-professional, multi-professional, and cross lateral, and also have hierarchical boundaries. The interactions that occur as a result are important in how community learning disability nurses enact their public health roles, and this study explored, described, and explained the significance of these interactions.

2.1.3 Mead's work was the first to be of direct relevance to role theory for this current study (Mead 1934). What was important for this study was Mead's concept of '*role taking*'. This current study explored how community learning disability nurses perceived and understood their public health roles. How roles are perceived and understood is important to '*role taking*'. Mead's work developed



into what is now commonly known in sociology as the school of symbolic interactionism. It is not clear in the literature how the concept of *'role-taking'* developed and evolved. However, this concept was relevant and important to this study and its definition necessitates further exploration. Coutu (1951) has defined it as a theoretical distinction between one's own role from the overt enactment of a role that would be considered to be of another. Conway (1988, p.63) has defined role taking as;

*'The reflection of an understanding of the generalised attitudes of others in one's actions (Turner 1962) and directing self accordingly (Charon 1979).'*

The notion of reflexivity inherent in this approach to role taking is important in understanding how community learning disability nurses enact their public health roles. This definition importantly suggests that role taking has much to do with how an individual views how others evaluated their roles. The language of role taking has evolved and has been refined over time, and the word *'encroachment'* has appeared in literature (Eaton and Webb 1979; Lauzen 1992; Mesler 1991; Ostwald and Abanobi 1986; Spilbury and Meyer 2004; Trossman 2005; Gomez 2006). However, there are limited studies of this concept in nursing, and none in community learning disability nursing. Existing studies on *'role encroachment'* in nursing relate to encroachment on nursing roles rather than on role encroachment by nurses and they were therefore not relevant to this study. Studies by Eaton and Webb (1979), and Mesler (1991) have investigated role encroachment in pharmacy practice. These studies raised issues, which were pertinent to this study, particularly Mesler's study. Lauzen's study (Lauzen 1992), investigated role encroachment in public

relations. The study raised a number of issues, which were relevant to this present study.

2.1.4 Mesler (1991) has noted that changes to medical practice resulted in role extension and role encroachment in pharmacy practice. The shift towards preventative practice in community learning disability nursing resonates with this analysis. As learning disability nurses assimilate new public health roles; role extension, role encroachment, and boundary encroachment (Alaszewski 1977; Eaton and Webb 1979) are likely to occur. What was not clear from these studies were the policy, organisational, and individual moderators of role extension and role encroachment. This present study sought to identify and explain some of these moderators. Mesler (1991) has concluded that role extension and boundary extension potentially impact on others' professional roles. In the UK, public health practice is multi-professional, and this observation by Mesler (1991) is very likely to be of significance in how community learning disability nurses enact their public health roles. Another important observation made by Mesler (1991) was that role encroachment and '*role delegation*' processes co-existed in practice, and boundary encroachment was inevitable. Another important observation by Mesler (1991) is the potential for role conflict where role encroachment and boundary encroachment exist. However, what was not clear from the literature was how the resulting role conflict impacted on how individuals enacted their roles. Understanding how community learning disability nurses enact their public health roles where role conflict exists would add invaluable knowledge to our understanding of community learning disability nursing public health practice. Another useful observation made by Mesler (1991) was the failure of role encroachment and

boundary encroachment theories to sufficiently account for occupational interactions, and their impact on role enactment. Given these observations, it would not be unreasonable for one to conclude that the presence of role ambiguity, and absence of role clarity in themselves would not be sufficient in explaining how community learning disability nurses enact their public health roles. In stages 2 and 3 of this study, moderators of how community learning disability nurses enacted their public health roles were described and explained respectively.

2.1.5 Lauzen (1992) has investigated role encroachment in public relations. At the superficial level this might appear an odd choice for a literature review on the public health role of the community learning disability nurse. Lauzen (1992) made two observations, which in my view have wider implications to our understanding of the concept of role theory, and in particular '*role enactment*'. The first of these observations was to do with her conclusion that a '*role vacuum*' is created when roles are not enacted. In the context of this study, one could conclude that where there is a vacuum in the implementation of public health policy for people with learning disabilities, community learning disability nurses may be more likely to extend their roles to occupy the vacuum. The second of these observations stemmed from her conclusion that;

*'...public relations practitioners with manager role aspirations and manager role competencies are likely to enact the manager role'*  
(Lauzen 1992, p. 66).

Firstly, this observation was important in that one could conclude that role encroachment was likely to occur where the nurses involved were competent in performing the roles in question. Secondly, this conclusion suggests that role

encroachment is an active and deliberate act on the part of those encroaching on the roles in question. In my view this conclusion needed to be explored, described, and explained in order for us to have a better understanding of how community learning disability nurses enact their public health roles.

2.1.6 Most of Moreno's work has focussed on psychodrama and sociodrama (Moreno 1953, 1960a). He made significant contributions to cognitive / psychological role theory. The words '*role*' and '*role playing*' appeared in his first English language publication, '*Who shall survive*', (Moreno 1934, 1953). His contribution to role theory was better articulated in his later work (Moreno 1960a, 1960b). Moreno's work identified three distinct roles; psychosomatic, psychodramatic, and social (Moreno 1953, 1960a). Moreno's contributions to role theory that were important in this study were his ideas that the formation of roles progressed through predominantly two stages of *role perception* and *role enactment* (Moreno 1960b). The current study sought to describe how learning disability nurses perceived their roles, and explained how they enacted their public health roles. Role perception and role enactment were of great significance in this study, and warrant further exploration at this point.

2.1.7 Since Moreno's work (Moreno 1953, 1960a, 1960b), very little effort has been made at defining '*role perception*'. There seem to be very little literature on this very important element of role theory. This is rather very surprising given that perception is one of the most fundamental of human cognitive behaviours central to human actions (Saha 2008) in social and occupational environments. However, perhaps we can deduce the meaning of role perception from our

understanding, and application of the word perception itself. Perception was defined by Robbins as;

*'... a process by which individuals organise and interpret their sensory impressions in order to give meaning to their environment' (2005, p.134).*

What I learnt from this definition is that how community learning disability nurses interpret their public health roles is important in their understanding and enactment of those roles.

2.1.8 Saha (2008) concluded that;

*'Perception is a strong phenomenon as people usually act upon their perceptions. Perception thus transforms into reality. The absence of a distinctly defined role of an employee and an amorphous perception of their roles and responsibilities in the organisation may have a downturn effect in the employee's morale and self esteem. Role perception of the employees acts as one of the most critical components in the workplaces today. It also plays a key role in an individual's performance. A misty perception of role may also lead to under-performance and under- utilisation of the potential of the individual. Resultantly, the organisation may lose not only some vital man-hours but also some of the most competent employees in the long run. It is therefore, in the organisation's interest to provide a clearly defined role to every employee as a step towards combating the ever-increasing competition in the global purview' (Saha 2008, p.29).*

2.1.9 There are two points in these conclusions that in my view are of significance to this current study. Firstly, the notion that '*perception*' transforms into reality is an important one. In other words it could be argued that how community learning disability nurses perceive their roles translate into their experience in the work place. Clarity of these perceptions would be important in our understanding of how community learning disability nurses enact their public health roles. This in turn is likely to be significant in how public health policy is implemented for people with learning disabilities. Secondly, Saha's conclusion for the need for employing organisations to clearly define roles for their employees was an important one for this study (Saha 2008). This present study investigated the significance of role clarity in how community learning disability nurses perceived and enacted their public health roles. Investigating how public health roles were defined in community learning disability nurses' job descriptions or person specifications was important in exploring how this may have impacted on how these roles were enacted. It was also important to evaluate how employing organisations influenced how community learning disability nurses perceived and enacted their public health roles.

2.1.10 Saha (2008) has argued that in order for individuals to execute their roles and their responsibilities effectively in any organisation, organisations needed to ensure that job descriptions and person specifications have clarity. This means that role perception could become a significant phenomenon where there is a lack of role clarity. In other words, community learning disability nurses' perceptions of their roles could be important in their understanding of their role expectations and role boundaries (Saha 2008). In turn understanding role

expectations and role boundaries is likely to impact on how community learning disability nurses enact their public health roles.

2.1.11 Recent studies on how nurses perceive their roles exist (Mellor and St John 2007; Lu *et al.* 2008; Stevenson *et al.* 2011; Pavlish and Ceronsky 2009; Kellogg 1995; Croghan *et al.* 2004; Hanafin 1998; Aston *et al.* 2009; Boarder 2002; Parahoo and Barr 1994). Of these studies Kellogg (1995), Croghan *et al.* (2004), Hanafin (1998) and Aston *et al.* (2009) have investigated how nurses perceived their public health roles. The exploratory study by Boarder (2002) on the perceptions of community learning disability nurses of their roles and ways of working is the only study identified that partially explored some public health roles undertaken by community learning disability nurses. In addition to the detailed exploration of the roles of community learning disability nurses, the current study described moderators of how they enact those roles and explained relationships that impacted on how they perceived, and enacted those roles.

2.1.12 In its original use in theatre, role enactment refers to the behaviour, movements, verbal and gestures of performance, and dress code an actor adopts when participating in theatre performance (Sarbin 1986). According to Sarbin (1986) roles can be enacted at varying levels of involvement, depending on the actor's level of cognition of that role. This is of significance to the current study because it suggests that the degree to which community learning disability nurses engage with public health policy implementation could be dependent on their cognition and perception of that policy. In the current study it was therefore important to explore, describe, and explain how community

learning disability nurses understood and enacted their public health roles in response to public health policy initiatives.

2.1.13 Role enactment is also called role behaviour (Newcomb 1950), role performance, and role interpretation (Fondas and Stewart 1994). The use of such a wide range of terminology, which refers to the same concept, is rather confusing. However, what is clear from the literature is that the concept relates to how successfully an individual enacts their prescribed role. In this present study it refers to how community learning disability nurses enact their public health roles. A limited number of relevant studies in role enactment in health policy or public health policy implementation exist (Scott 1995; Squires 2004; Fitzgerald *et al.* 2006). The study by Fitzgerald *et al.* (2006) involved an analysis of role enactment by non-clinical NHS managers, and therefore it is not considered in any detail at this point. In a study of role and role enactment by nurses and doctors, Scott (1995) has concluded that the quality of how nurses enacted their clinical roles impacted on patient care. This is of significance to the current study because it suggests that the quality of how community learning disability nurses enact their public health roles could directly impact on how people with learning disabilities experience access to public health services. In a study analysing role enactment by nurses in acute care settings Squires (2004) has concluded that the process of role enactment was multidimensional. Of importance to the current study is the need for autonomy for successful role enactment (Squires 2004; Irvine-Doran *et al.* 2002; Prothero *et al.* 1999; Tonges *et al.* 1998). This observation suggests that how community learning disability nurses enact their public roles may be influenced by the degree of autonomy they possess in enacting their roles. In



addition, Squires (2004) has cited studies, which demonstrated that role clarity was an important dimension in how nurses enacted their roles (Scott 1995; Barter *et al.* 1997; Boyle *et al.* 1996; Irvine-Doran *et al.* 2002). Overall, what was important for the current study from the conclusions made by Squires (2004) was the need to explain the relationships between role clarity and community learning disability nurses' public health role enactment.

2.1.14 Ralph Linton was a renowned social anthropologist whose work focused on the relationship between role and status or position (Linton 1936). Linton (1936) propositioned that roles are dynamic representations of positions which individuals occupy. He described a status or position as a collection of duties. Linton's main point was that individuals enact their roles when they effect their duties. This is important for the current study. Stage 1 of the current study explored the clarity of learning disability nurses' '*duties*' in job descriptions or person specifications. The clarity of '*duties*' or absence thereof is likely to impact on how community learning disability nurses enact their public health roles.

2.1.15 As the concept of role evolved, so did the language itself. At the inception of role theory in the 1930s there was a single notion of role. As the concept evolved, the language of role was increasingly refined. At the same time a number of authors began to use the word '*role*' adjectively to modify a wide range of other concepts such as conflict, set, behaviour, enactment, conception, perception, and others. While a detailed exploration of these developments would be beyond the scope of this thesis, notable theorists include Davis (1949), Parsons and Shils (1951), Levinson (1959), Gouldner

(1960) and many others. The use of the word '*role*' adjectively has been widely used in a wide range of contexts in this thesis.

2.1.16 What emerges from the literature is an extensive 'adjective' use of the word '*role*'. These different uses have led to anthropological, sociological, and psychological interpretations of '*role*'. This has led to considerable ambiguity and confusion regarding how role should be defined (Neiman and Hughes 1951; Gross *et al.* 1958a; Banton 1964). The first attempt at collating the definitions of role as a concept can be traced to Thomas and Biddle (1966b). Thomas and Biddle (1966b) identified three commonly used definitions of '*role*' in role theory (see *Table 2a*). However, although these definitions were fundamental to the current study, they fail to adequately articulate role in the context of organisational role theory (see *Table 2b*). Although the definition of role has remained denotative, its clarity has improved over time, and there has been continuous, and progressive elaboration, and purification of the definition. Thomas and Biddle (1966b, p.29) have noted that the word '*role*' was used to refer to '*prescription, description, evaluation, and action*', and was used with reference to overt, and covert processes. It is clear that there is no universal definition of role. However, it is clear from the literature that in cognitive, and organisational role theories, the term refers to behaviours of individuals occupying a particular position. This view is consistent with the view put forward by Linton (1936). Another important observation here is that whatever definition one may adopt (see *Table 2a*), it is likely to be restrictive and confining.

Table 2a: Definitions of role (Thomas and Biddle 1966b, p.11-12).

<b>Role</b>	1. A behavioural repertoire characteristic of a person or a position.
	2. A set of standards, descriptions, norms, or concepts held (by anyone) for the behaviours of a person or a position.
	3. A position.

2.1.17 This thesis adopts a definition offered by Banton who defined role as a ‘*set of norms and expectations applied to the incumbent of a particular position*’ (Banton 1965, p.29). Biddle and Thomas (1966b) have noted the importance of how the meaning of role was interpreted in role perception and role enactment. In further work, Biddle (1986) has described five major perspectives of role theory and they include; functional role theory, symbolic interactionist role theory, structural role theory, organisational role theory, and cognitive role theory. Of interest in this study is organisational role theory and cognitive role theory, and these concepts are explored further later in this chapter. What emerges from literature is the misnomer of the term ‘*role theory*’. The use of the word ‘*theory*’ itself is problematic. The word theory originated from the word ‘*theoria*’, which originated from ancient Greek philosophy meaning contemplation or speculation. In modern philosophy a theory is an empirical framework, which describes a phenomenon. Another problem is that the word role originated in theatrical usage and relates to a part played by an individual in a drama (Conway 1988). What is clear from literature is that role theory does not refer to a logical and testable hypothesis. It refers to a wide range of

concepts and assumptions that predict an individual's behaviour in a defined role. This lack of an all-encompassing role theory was summarised by Biddle (1979, p.18);

*'The field of role consists of many hypotheses and theories concerning particular aspects of a domain, but these propositions like the knowledge to which they relate, have yet to be reviewed and integrated. And even if the propositions were brought together in some organised form, they would undoubtedly not constitute a single, monolithic theory of the sort that the appellation role theory implies, nor would they always be distinguishable from other theoretical statements in such disciplines as psychology, sociology and anthropology'.*

2.1.18 Many assumptions of role exist. Biddle (1986, p.67) noted '*confusions and disagreements over use of role concepts*' arising from the differing perspectives in which role studies take place. Biddle (1986) has described five major perspectives in role theory (see *Table 2b*). Given the extent of what constitutes role theory, it is important to discriminate the cognitive and organisational role theory perspectives that were relevant to this current study.

## **2.2 Organisational and cognitive role theories**

2.2.1 Organisational role theory deals with how individuals accept and enact their roles in task-oriented hierarchical and pre-planned formal organisations (Biddle 1986; Madsen 2002). What was important for this study is that roles in these organisations are associated with employment positions and normative expectations. Perhaps of more interest is our understanding of how

individuals enact their roles when expectations are ambiguous to the individual and the organisation. Role ambiguity is discussed later in this chapter.

*Table 2b: Major models of role theory (Biddle 1986).*

<b>Theory</b>	<b>Area of study</b>
Functional role theory	Examines role development of social positions.
Symbolic interactionist role theory	Examines role development as the outcome of individual interpretation of responses to behaviour.
Structural role theory	Examines the influence of society rather than the individual in roles and utilises mathematical models to explain the roles.
<b><i>Cognitive role theory</i></b>	Examines the relationships between expectations and behaviours.
<b><i>Organisational role theory</i></b>	Examines role development in organisations.

2.2.2 The origins of organisational role theory can be traced back to Gross *et al.* (1958b), and Kahn *et al.* (1964). Since then, the theory has been of significant interest to industrial psychologists, and has had a significant impact on our understanding of formal organisations (Biddle 1986). Much of the studies available that are relevant to this study have focussed on role conflict, role transition, role taking, and role ambiguity in formal organisations (Moreno 1953, 1960a; van de Vliert 1981; Fisher and Gitelson 1983; Allen and van de Vliert 1984; Mesler 1991; Lauzen 1992; Miller *et al.* 2000; Tunc and Kutanis 2009). What is of interest in all these studies is how individuals deal with

changes to the expectations of their role, and especially when that role is ambiguous to the individual and to the organisation.

2.2.3 It is expected that employees '*take*' the role defined by their employer when they accept an employment position (Katz and Kahn 1978). What is not clear from previous role theory studies, and which needed further investigation is how lack of role clarity impacts on how community learning disability nurses interpret, and enact their roles. This study adds new knowledge, and new understanding on how community learning disability nurses enact their public health roles in the absence of role clarity. Literature relating to role ambiguity is discussed later in this chapter. At this point I will look at the origins of cognitive role theory and its significance to the current study.

2.2.4 Cognitive role theory can be traced back to Moreno (1934, 1953) with his writings on role-playing and has become a key field in cognitive social psychology. In practice, most of this work has sought to address the impact of role expectations on individual behaviour. From Moreno's work a large volume of studies now exist. This work falls into a number of subfields of cognitive role theory; therapeutic role playing (Moreno 1934; Janis and Mann 1977); leadership role theory (Sherif 1936; Moreland and Levine 1982; Hollander 1985; Stordeur *et al.* 2001); anticipatory role theory (Rotter 1954; Duckro *et al.* 1979; Wright *et al.* 2001; Gilliband *et al.* 2004; Moore *et al.* 2007; Kennedy *et al.* 2011), and role taking (Mead 1934; Eaton and Webb 1979; Underwood and Moore 1982; Eisenberg and Lennon 1983; Chappell and Barnes 1984; Mesler 1991; Lauzen 1992; Trossman 2005). What is of significance for this present study is the limited number of studies that investigated role taking in

nursing, and more-so the complete absence of studies that investigated role taking in community learning disability nursing practice.

2.2.5 According to Kahn *et al.* (1964), and Beehr (1976) role ambiguity refers to the lack of specificity and predictability for an individual employee's job or role functions and responsibilities. Lack of clarity on role expectations is likely to lead to role ambiguity. Existing literature show that there are four major dimensions of role ambiguity (Bedeian and Armenakis 1981; Jackson and Schuler 1985; Breaugh and Colihan 1994; Singh *et al.* 1996). These studies show that these dimensions relate to goals, process, priority, and behaviour. According to Kahn *et al.* (1964), and Miles (1974) role ambiguity results in role conflict, role stress, and role overload. In addition, Rizzo *et al.* (1970), and Singh (1998) have demonstrated that role ambiguity is negatively correlated with how individuals enact their occupational roles. However, a study by Willcocks (1994) concluded that the impact of role ambiguity is circumstantial. The study showed that in some situations individuals would consider role ambiguity as an opportunity to be exploited while for others role ambiguity would be a source of conflict, frustration, and stress. This observation was relevant for the current study and necessitated the need to investigate how community learning disability nurses may react to role ambiguity.

2.2.6 No studies, which addressed role ambiguity in community learning disability nursing, could be located. However relevant studies in other fields of nursing exist (Smith 2011; Pryor 2007; Tarrant and Sabo 2010; Gormley and Kennely 2010; Philibin *et al.* 2010; Tunc and Kutanis 2009; Gagan 2002; Chang and Hancock 2003; Zimmerman *et al.* 1996; Acorn 1991; Miller *et al.* 2000;

Rungapadiachy *et al.* 2006). According to Gagan (2002), role ambiguity in nursing is rooted in the dialogical, and practice ambiguity of the concept of nursing itself. Rungapadiachy *et al.* (2006) in a study of how newly qualified mental health nurses perceived their nursing roles concluded that the role of the mental health nurse was ambiguous because of the wide variety of tasks it entailed. This view has significance for this study for newly qualified community learning disability nurses. Chang and Hancock (2003) have compared role ambiguity between nursing graduates and more experienced nurses in Australia. The study concluded that role ambiguity was a more significant cause of role stress among the newly qualified nurses while role overload was more significant in causing role stress in more experienced nurses. This conclusion was significant for this current study since it described the relationship between nurses' position and role clarity, and, or, role ambiguity. Pryor (2007) has identified lack of role preparation; heterogeneity of the role set, and poorly articulated job roles as significant contributors to role ambiguity. Stage 1 of this current study explored the clarity of roles in job descriptions and person specifications for community learning disability nurses. In addition to Pryor's observations (Pryor 2007) regarding the impact of lack of role preparation on role ambiguity, Smith (2011) has noted that nurses needed to expect role ambiguity and role conflict as they take on new roles. Moreover, Philibin *et al.* (2010) have advocated the need for redefinition of roles in response to practice and policy changes. Conclusions by Pryor (2007), Philibin *et al.* (2010), and Smith (2011) are of significance if community learning disability nurses are to be effective in enacting their public health roles and public health policy implementation for people with learning disabilities. These conclusions were addressed in stages 2 and 3 of this



current study. Another theme that emerges from these studies is the significance of employing organisations in role ambiguity. Ross and Ross (1981) have concluded that role ambiguity in nursing was related to organisational commitment to the nursing roles involved. Community learning disability nurses find themselves working in organisations whose priorities is not necessarily the implementation of public health policy for people with learning disabilities. Evaluating the commitment of employers of community learning disability nurses to public health policy implementation for people with learning disabilities is therefore important in understanding how community learning disability nurses enact their public health roles. The organisation of health and social care in the UK mean that community learning disability nurses find themselves employed in a variety of differing organisations. Zimmerman *et al.* (1996) in a study of role ambiguity among school nurses observed that role ambiguity was influenced by the fact that two employers jointly employed the nurses. However, these conclusions contradicted an earlier study by Acorn (1991). The study by Acorn (1991) has concluded that clinical-academic joint appointments of nurses did not necessarily lead to increased role ambiguity. Given that joint appointments exist in community learning disability nursing practice in the UK, it was important in this current study to seek to explain the relationships between employing organisations and role ambiguity.

2.2.7 Iliopoulou and While (2010), in a survey of critical care nurses in Greece, have demonstrated a moderate positive association between role distance and role ambiguity. Understanding how public health policy is translated into public health roles for community learning disability nurses was therefore important

in evaluating how they enact their public health roles in implementing public health policy for people with learning disabilities. In separate studies, Tarrant and Sabo (2010), and Gormley and Kennely (2010) have observed strong negative correlations between role ambiguity and role conflict. In addition, Tunc and Kutanis (2009) have noted strong positive correlations between role conflict and role ambiguity, and burnout. These conclusions have implications on how community learning disability nurses are involved in implementing public health policy for people with learning disabilities, and therefore needed further investigations.

## **2.3 Role theory in community learning disabilities nursing**

2.3.1 Role theory literature with respect to learning disability nursing roles is very limited, and more so literature which addressed community learning disability nurses' public health roles. Few examples of literature exist, for example, community nursing roles (Jukes 1994; Mansell and Harris 1998; Mobbs *et al.* 2002; Barr *et al.* 1999; Barr 2004,2006), and advocacy role (Gates 1994; Llewellyn 2005; Llewellyn and Northway 2007). This current study sought to build on existing knowledge on role theory in nursing by exploring; describing and explaining how community learning disability nurses enact their public health roles.

2.3.2 Jukes (1994) has traced the origins of the learning disability nurse's involvement with public health for people with learning disabilities to the 1960s. In the 1980s several attempts were made to identify and clarify the contribution of community learning disability nurses to health promotion (RCN 1985; Elliot-Cannon 1981). The Griffiths Report (Griffiths 1988), and the NHS

and Community Care Act (DH 1990) emphasised the '*health*' contribution of community learning disability nursing. More recently, the Department of Health has clearly emphasised the public health role of the learning disability nurse in England (DH 2001; DH 2007c). However, there is a lack of clarity in how this role is supposed to be carried out in practice. This is primarily because community learning disability nurses find themselves occupying the grey area between healthcare services and social care services. Consequently, defining a public health role of the community learning disability nurse has been difficult (Mobbs *et al.* 2002). It is therefore not surprising that this role has evolved differently across the UK (Mobbs *et al.* 2002), and that primary care and social care services have a conflicting understanding of the role and contribution of community learning disability nurses to the delivery of public health policy to people with learning disabilities (McGarry and Arthur 2001). There is very little research into the learning disability nurses' role, practice, and contribution to public health policy implementation for people with learning disabilities (Boarder 2002). Recent research on the role of community learning disability nurses has concentrated on their broader professional roles such as advocacy (Gates 1994; Jukes 1994; Mansell and Harris 1998; Stewart and Todd 2001; Alaszewski 1977; Mobbs *et al.* 2002; Llewellyn and Northway 2007), and generic community nursing roles (Holloway 2004; Melville *et al.* 2005; Thornton 1996; Thornton 1997; Boarder 2002; Powell *et al.* 2004). As the NHS shifts its focus from treatment to wellbeing and preventative services, investigating how community learning disability nurses will contribute to the implementation of public health policy for people with learning disabilities has become even more urgent.

2.3.3 In recent years a public health role of English learning disability nurses has been clearly outlined (DH 2007b). This highlighted that the learning disability nurse has a key public health role in a number of key areas including contributing to public health policy development; planning public health policy implementation; and taking a lead role in the implementation and delivery of public health policy for people with learning disabilities. This study is therefore important because it sought to explore, describe, and explain how community learning disability nurses enact their public health roles.

2.3.4 Although there are limited studies regarding the involvement of community learning disability nurses with public health policy implementation, important themes pertinent to this study emerge from literature. One of these themes is the complexity and increasingly specialised role of the community learning disability nurse (Mobbs *et al.* 2002), the learning disability nurse's contribution to public health through health facilitation, health promotion, and health education (Bollard 2002; Marshall and Moore 2003; Barr *et al.* 1999), and the positive regard for learning disability nurses by other primary care professionals (Stewart and Todd 2001). However, some of these themes raised significant questions, which necessitated a need for further exploration in the current study. The lack of in-depth research evidence, which has evaluated and validated the public health role of community learning disability nurses needs to be addressed in order to demonstrate their positive contributions to how public health policy is implemented for people with learning disabilities. Perhaps, what is of greater concern in the current literature is the lack of public health role clarity among learning disability nurses themselves, lack of clarity among other public health professionals,

and lack of clarity in primary care organisations (Boarder 2002; Hames and Carlson 2006; Mobbs *et al.* 2002; Stewart and Todd 2001). Studies have shown that lack of role clarity presents a challenging and significant impediment to the successful implementation of health policy (Fyson 2002; Ross 2001). Taylor (1996) has noted that lack of role clarity, confused and ambiguous expectations between healthcare professionals resulted in reduced quality of care. On the other hand clarity of role expectations are beneficial by improving communication, flexibility, and responsiveness at every level of healthcare policy implementation (Taylor 1996). At this point it would be appropriate to explore literature that addressed the significance of job descriptions and person specifications in clarifying occupational role expectations.

## **2.4 Purpose of job descriptions**

- 2.4.1 A job description is an employer designed formal document, which identifies a role occupier's employment requirements and role expectations (Levin and Weiss-Gal 2009; Mitchell 1982; Stenmark 2000; Ducey 2002). In addition, a job description is an instrument '*...for clarifying the boundaries and content of jobs*' (Torrington *et al.* 2002, p.84). Furthermore, Forchuk *et al.* (2002, p.479-480) have described a job description as a document that is a;

*'....cornerstone for the employer and the employee in understanding job function, responsibilities, accountability and authority in the workplace'.*

According to Mafuba (2012a) employers need to ensure clarity and accuracy of job descriptions in order to ensure effective role enactment. In addition, according to Wick (2007), a job description is a guide for an employee's

activities, and constitutes a statement of what duties and responsibilities an employee is expected to perform. In addition, Forchuck *et al.* (2002) has argued that job descriptions are often reflections of organisational philosophies and organisational values. Literature suggest that job descriptions constitute a type of contract between employees, and employing organisations highlighting the employer's expectations of the employee and at the same time highlighting the perceptions of employers' priorities, and professional values of the employee (Sidani and Irvine 1999). It would be inappropriate to argue that job descriptions reflect the totality of what community learning disability nurses actually do in enacting their public health roles. It would also be ill conceived to conclude that job descriptions can represent the complete sum of formal and informal expectations of employers on community learning disability nurses. However, job descriptions can be indispensable instruments in validating how employers perceive the roles played by their employees (Levin and Weiss-Gal 2009; Corazzini *et al.* 2010). It could therefore be argued that an analysis of community learning disability nurses' job descriptions and person specifications is important in highlighting how they are expected to enact their public health roles. In addition, such an analysis would demonstrate community learning disability nurses' employing organisations' commitment to, or, lack thereof to the implementation of public health policy for people with learning disabilities.

2.4.2 A written job description has a number of advantages (Chaffner 1990; Wick 2007). Wick (2007) has identified the articulation of a role's skill set, communication of role expectations by the employing organisation and articulation of formal instructions for responsibilities as some of the benefits of

a clear job description. In other words articulate job descriptions could be an important foundation for role clarity. This also suggests that the clarity of job descriptions is key in clarifying role expectations between the employing organisation and its staff. Torrington *et al.* (2002) have argued that job descriptions are crucial in work environments where roles and responsibilities overlap. The authors also argued that job descriptions and person specifications are crucial where there is significant role distance (Torrington *et al.* 2002). Community learning disability nurses often work in situations of professional, managerial, and geographical isolation. Therefore clear job descriptions are likely to have a significant impact on how they enact their public health roles.

2.4.3 Grensing-Pophal (2000) has pointed out that there is a widespread view that;

*‘...job descriptions serve a critical purpose in ensuring that job holders have consistent expectations about the requirements of each position’*  
(p.32).

Furthermore, Marino (2005) has argued that when job roles are clearly defined and mutually understood, role boundaries become clearer to the role set. In this situation it is then arguable that when roles are mutually accepted, the performance of the roles is less ambiguous. This position is quite significant for the current study in that it suggests that well prepared job descriptions are useful in ensuring that organisations make it explicit what is to be accomplished by community learning disability nurses. For community learning disability nurses this may mean that they would be able to understand which public health policies they are expected to implement for people with learning disabilities and what public health roles they are

expected to play. According to Grensing-Pophal (2000) useful job descriptions are those that are agreed between the employee and the employer. In addition, a job description needs to be '*a living document*' (Grensing-Pophal 2000, p.36). Wick (2007) has concurred with this view and has suggested that notations of current job descriptions are emphasised. Wick (2007) has further argued that when roles are clear for employees they are more likely to be proactive in the effective and efficient enactment of those roles. In addition, Marino (2005) has further argued that for employees to enact their roles effectively it is vital that job descriptions are accurately maintained. On the other hand Torrington *et al.* (2002) have noted that some analysts have argued that job descriptions are increasingly being viewed as bureaucratic, constraining, and potentially inhibit staff's ability to be innovative. Furthermore, Wick (2007) has noted that there have been recent arguments that job descriptions have become increasingly obsolete due to the trend of self-directed lone working. However, the author also argued that there was real value in ensuring that job descriptions for each employee in an organisation are clearly written, and current. Another important point noted by Wick (2007) was the constant reorganisations in what, and how work is organised and carried out. In the presence of such constant change the author has argued that job descriptions have become indispensable tools for preventing role conflict and chaos in the work environment. UK health and social care services are constantly changing. Therefore clear job descriptions are likely to be positive moderators of how community learning disability nurses enact their public health roles.



2.4.4 No studies, which have investigated the job descriptions of community learning disability nurses, could be located. However, other relevant studies exist, and their relevance to the current study is addressed here. Grant (1997) undertook a study in the United States of America involving staff from 60 different organisations. Of the staff that participated in the study, 85% reported that they felt that their job descriptions were unclear and failed to clarify their employers' expectations of their roles (Grant 1997). A number of reasons were cited as the main causes of this ambiguity. The staff reported that their job descriptions were inaccurate, incomplete, and vague. These observations can only lead to lack of role clarity and it is useful to evaluate how, in the event of similar observations in the current study how this impacts on how community learning disability nurses enact their public health roles. In the same study key elements of employers' role expectations were not included in job descriptions in 70% of the staff that participated. What can only be concluded from this lack of role clarity is that it could negatively impact on how staff enacted their roles (Grant 1997). Another observation made in the study that is of significance to the current study was that the managers' failure to ensure clarity of job descriptions resulted from their assumptions that staff knew what their roles and responsibilities were (Grant 1997). Investigating the clarity of community learning disability nurses roles would enhance our understanding of the moderators of how they enact their public health roles.

2.4.5 A study involving nurses undertaken by Wei *et al.* (2011) in Taiwan concluded that nurses who received clearly defined roles and explicit job descriptions had positive perceptions of their roles. The study also concluded that positive role perception was important in role taking, and had a positive impact on how

nurses enacted their roles (Wei *et al.* 2011). In this current study I sought to investigate whether role clarity in job descriptions contributed positively to how community learning disability nurses enacted their public health roles.

2.4.6 Endacott and Chaboyer (2006) undertook a study in Australia, and in England that was of relevance to this current study. The study used job descriptions as sources of evidence in the investigation of nurse consultant roles in the context of advanced nursing practice. In both countries job descriptions highlighted the need for incumbents to influence hospital policy (Endacott and Chaboyer 2006). These observations were of significance in stage 2 of the current study. Evaluating how learning disability nurse consultants engage with public health policy for people with learning disabilities is vital in shedding light on how they enact their public health roles.

2.4.7 A study by Kudless and White (2007) involved mental health nursing roles in the context of an ever-changing policy and clinical environment. The authors observed that there was a need to emphasise new roles in job descriptions as the needs of the population changes (Kudless and White 2007). These findings suggest a need for changes to community learning disability nurses' job descriptions in the context of policy changes. How employing organisations of community learning disability nurses ensure that re-evaluations of roles are undertaken, and changes made to job descriptions in the event of public health policy changes was an important element of this current study.

2.4.8 In the UK there has been a recent national re-evaluation of job descriptions of all NHS staff through *Agenda for change* (DH 1999c). Studies evaluating the impact of *Agenda for change* on nursing roles have recently emerged (Watts and Green 2004; Jay and Tanner 2004; Bridges *et al.* 2007; Jenkins 2007; McClimens *et al.* 2010; Kahya and Oral 2007; Buchan and Ball 2011). There were two important points for exploring the rationale for job evaluations in this present study. Firstly, according to Werther and Davis (1993) job evaluations are useful in assessing the relative importance of jobs. Secondly, according to Welbourne and Trevor (2000) job evaluations are important in assessing the contribution of each job to an organisation. In the new classification of NHS nursing roles, there are six groups of nursing roles, and these include community nursing (Kahya and Oral 2007). The job profiling process evaluated job roles based on sixteen factors (see *Table 2c*). Within each factor, roles were defined for each nursing band. This was useful in formulating the '*a priori*' theoretical categories for stage 1 of the study, and formulation of interview and survey questions in stages 2 and 3 of the study. One of the key purposes of *Agenda for change* was to ensure consistency of job descriptions and role expectations across the NHS. At the commencement of the study it could be argued that it was reasonable to expect a high level of consistency of role expectations in job descriptions, and public health role clarity in job descriptions for community learning disability nurses. Evaluating this assumption was one of the key aims of this study in the exploratory phase.

*Table 2c: Extracts from National profiles of community learning disability nurses (DH 2006c).*

<b>Band</b>	<b>Factors</b>	<b>Roles</b>
5	Patient / client care	<ol style="list-style-type: none"> <li>1. Develop programmes.</li> <li>2. Provide specialised advice.</li> <li>3. Assess health needs.</li> </ol>
	Policy	<ol style="list-style-type: none"> <li>1. Follow policy in own role.</li> <li>2. Contribute to policy development.</li> </ol>
6	Patient / client care	<ol style="list-style-type: none"> <li>1. Develop specialised programs of care.</li> <li>2. Provide specialised advice.</li> <li>3. Assess health needs.</li> <li>4. Implement specialised programs of care.</li> </ol>
	Policy	<ol style="list-style-type: none"> <li>1. Implement policies.</li> <li>2. Propose changes to practices and procedures in own area.</li> <li>3. Comments and proposes changes for policies for own area</li> </ol>
7	Patient / client care	<ol style="list-style-type: none"> <li>1. Develop specialised programs of care.</li> <li>2. Assess health needs.</li> <li>3. Implement specialised programs of care.</li> </ol>
	Policy	<ol style="list-style-type: none"> <li>1. Propose policy or service changes, impact beyond own area.</li> <li>2. Participates in working groups to develop new policies for learning disability services, which impact beyond own work area.</li> </ol>
8*	Patient / client care	<ol style="list-style-type: none"> <li>1. Delivers highly specialised advice to the MDT across sectors.</li> <li>2. Accountable for service delivery.</li> </ol>
	Policy	<ol style="list-style-type: none"> <li>1. Responsible for policy implementation.</li> <li>2. Responsible for service development.</li> <li>3. Develop and implement integrated care policies.</li> </ol>
* There is no specific profile for Band 8 community learning disability nurses – this is generic.		

In addition to the *National profiles* for nursing jobs, a detailed *NHS knowledge and skills framework* was produced (DH 2004b). Within the *National skills framework* expectations were clearly outlined for each nursing band. These expectations were grouped into dimensions, and an important dimension for the current study was *Dimension HWB1* (DH 2004b). In this dimension the role of the nurse in the promotion of health and wellbeing, and prevention of adverse effects on health and wellbeing is clearly outlined (see *Table 2d*). At the commencement of the current study it could be argued that job descriptions of community learning disability nurses needed to reflect these expectations given that all job descriptions had been re-evaluated using the *NHS knowledge and skills framework*. Evaluating these assumptions was also an important element in stage 1 of the current study.

*Table 2d: The NHS knowledge and skills framework – Dimension HWB1:*  
Promotion of health and wellbeing and prevention of adverse effects on health and wellbeing.

<b>Level / Band</b>	<b>Roles</b>
1 / 5	Contribute to health and wellbeing, and preventing adverse effects on health and wellbeing.
2 / 6	Plan, develop and implement approaches to promote health and wellbeing, and prevent adverse effects on health and wellbeing.
3 / 7	Plan, develop, implement and evaluate programs to promote health and wellbeing, and prevent adverse effects on health and wellbeing.
4 / 8	Promote health and wellbeing, and prevent adverse effects on health and wellbeing through contributing to the development, implementation and evaluation of related topics.

What can be observed from *Dimension HWB1* is a clear outline of how community learning disability nurses are expected to enact their public health roles. What can also be noted from this dimension are role descriptors. These are outlined in *Table 2e* below. The identification of these descriptors during the *a priori* literature review was useful in how I approached data analysis in stage 1, and how I approached the formulation of questions in stages 2 and 3 of this study.

*Table 2e: Public health role descriptors (expectations) (The NHS knowledge and skills framework) (DH 2004b).*

<b>Band</b>	<b>Role descriptors</b>
<b>5</b>	<ol style="list-style-type: none"> <li>1. Promote</li> <li>2. Contribute (implementation)</li> <li>3. Prevent</li> </ol>
<b>6</b>	<ol style="list-style-type: none"> <li>1. Plan</li> <li>2. Develop (programmes)</li> <li>3. Implement</li> <li>4. Promote</li> <li>5. Prevent</li> </ol>
<b>7</b>	<ol style="list-style-type: none"> <li>1. Plan</li> <li>2. Develop (programmes)</li> <li>3. Implement</li> <li>4. Promote</li> <li>5. Prevent</li> <li>6. Evaluate</li> </ol>
<b>8</b>	<ol style="list-style-type: none"> <li>1. Implement</li> <li>2. Promote</li> <li>3. Prevent</li> <li>4. Evaluate</li> <li>5. Contribute (policy development)</li> <li>6. Develop (policies)</li> </ol>

2.4.9 Another observation that could be made from these expectations is their similarities to the Faculty of Public Health's 3 domains of public health, and the 9 key areas of public health (see *Box 1a*). An analysis of how these expectations were reflected in community learning disability nurses' job descriptions, and how this influenced public health role enactment (Moreno 1953, 1960b) was central to this study.

## **2.5 Conclusion**

2.5.1 The literature explored here has demonstrated that there are significant gaps in role theory regarding our understanding of how community learning disability nurses enact their public health roles in the implementation of public health policy for people with learning disabilities. Of significance in our understanding is the influence of clear job descriptions, which incorporate real-world role expectations, ensuring effective communication of public health role expectations (Grant 1997) for community learning disability nurses.

2.5.2 This present study contributes to role theory by exploring how public health policy is translated into job descriptions of community learning disability nurses, by describing how community learning disability perceive and enact their public health roles, and by explaining moderators of public health role enactment. In the next section I explain and rationalise my choice of the methods that I have employed in undertaking this study.

## **SECTION 2: RESEARCH METHODS**

### **Introduction**

Chapter 3 gives an outline of the study design. It begins by briefly outlining the importance of cosmology, ontology, and epistemology in knowledge creation. This is followed by an outline of the paradigm debates and then by a discussion of the rationale for a sequential multiple methods design adopted in this study; ethical considerations are also discussed in this chapter.

Chapter 4 explains the documentary method adopted for the exploratory phase (stage 1) of the study. The chapter begins by discussing the rationale for documentary analysis. This is followed by an outline of the approach to sampling and the documents sampled for the study. The approaches to data handling, and analysis are then discussed; the final section in this chapter addresses questions of validity and reliability.

Chapter 5 outlines the semi-structured interview method adopted for the descriptive phase (stage 2) of the study. The chapter begins by outlining the rationale for the semi-structured interview method used in this study. This is followed by a discussion of approaches to sampling, data collection, data transcription, and preparation for analysis. Grounded theory analysis is then discussed followed by an evaluation of the validity and reliability issues.

Chapter 6 explores the questionnaire survey method adopted for the explanatory phase (stage 3) of the study. The first section discusses the rationale for the questionnaire survey. This is followed by a brief explanation of the pilot study undertaken to test the questionnaire. Approaches to



sampling, online data collection, data handling and preparation for analysis, and data analyses are then discussed. The final section of the chapter explores validity and reliability considerations.

## **Chapter 3: Study Design**

### **Introduction**

This chapter details the methodological approach used to design, and implement this study. The first section explores the philosophical, ontological, and epistemological positions adopted for this study. In the second section I describe the overview of the study design. The third section locates this study within the paradigmatic continuum. The fourth section describes the rationale for the multiple method approach to the research. The fifth section explores and rationalises the sequential design of the research. The final section of this chapter addresses ethical issues.

### **3.1 Cosmology, ontology, and epistemology**

3.1.1 Cosmology, ontology, epistemology, and methodology are interconnected, and interact in the process of generating knowledge (Crotty 1998). In my view clarifying this interaction during a research project, especially qualitative research is as important as the outcome of the research process itself. This is because these positions interact and influence how knowledge is generated and understood.

3.1.2 In the context of research, cosmology refers to one's worldview. This is important because in essence it regards what one believes to be correct, and this broadly determines their choice of a study design. My own worldview reflects the embodiment of African cosmology, with a hint of Babylonian cosmology, and Multiversal cosmology, which in many ways contradicts the Aristotelian cosmology from which the scientific method emerged (Hetherington 1993). One key element of African cosmology that is important

to me as a researcher is that things are indivisible and interconnected. What is important for me from the Babylonian cosmological perspective is the concept of 'plurality of the whole'. The importance of Multiversal cosmology in this study comes from the view that there is 'infinity beyond what is known'. This multi-cosmological view of the world is evident in the multiple method design of this study. The sequential nature of the design also reflects my own acknowledgement of the distinctiveness of these differing cosmological positions.

### 3.1.3 One's cosmological position directly influences their ontological position.

According to Blaikie (2000), ontology refers to the claims and assumptions one makes regarding the nature of social realities, assumptions about what exists, what that existence looks like, and how what exists interacts with each other. In other words ontology is a theory of being, and my ontological assumptions deal with what I believe constitutes social reality. As with my own cosmological position, my ontological view is not static but is rather evolutionary, and this position is reflected in the sequential design of the study, which evolved from exploratory through descriptive to explanatory.

### 3.1.4 Rand (1982) has argued that every person has a philosophy, even if they were not conscious of it. It was important for me as a developing researcher to explore and understand my philosophical position because this influenced how I planned and implemented this study. According to Quinton (1995, p.666);

*'Philosophy is rational critical thinking, of a more or less systematic kind about the general nature of the world...the justification of belief...and the conduct of life'.*

Teichmann and Evans (1999) have described philosophy as a study of ultimate and abstract problems. According to Grayling (1998, p.1);

*'The aim of philosophical inquiry is to gain insight into questions about knowledge, truth, reason, reality, meaning, mind, and value'.*

In other words philosophy seeks to generate knowledge that shape our beliefs and values.

3.1.5 Epistemology makes explicit the rules of correct knowledge creation and belief formation, as Brechin and Sidell (2000, p.5) pointed out that;

*'The reason why it is important to think explicitly about how we come to 'know' things, and on what basis such knowing is accepted, is that such knowledge affects what we do'.*

One's understanding of epistemology deals with what one considers to be valid knowledge at two levels. Firstly, it deals with what is knowledge. Secondly, it deals with how knowledge is acquired. What is important for me here is to explain my own epistemological position in how knowledge is acquired in relation to current epistemologies.

3.1.6 Until recently the predominant epistemological position was from the positivist tradition, which believes that knowledge can only be generated through the scientific method. However, my view is that researching people is fundamentally different from the natural sciences (Dilthey 1976), and hence the need for a subjectivist epistemological position. The problem I find is that it is difficult to reconcile these two epistemological positions because they are always seen as distinct and purist, and each view the world as binary. The works of Guba and Lincoln (2005), Denzin and Lincoln (1994), Geertz (1993),

and Eisner (1997) were quite useful as I struggled to locate my own epistemological position within the current contradictions. The link between my worldview and my view of 'self', and my understanding of what knowledge I sought to be validated is how I went to discover it and how that knowledge is presented to the reader in this thesis. The lesson from Guba and Lincoln (2005) was from their observation of the increasing acknowledgement of the value of knowledge gained through interpretive enquiry even among positivists. In addition, van Dalen and Meyer (1962, p.26) have noted that; '*...the scientific method does not lead to absolute certainties...*'. What was of importance for me from Denzin and Lincoln (1994) was their conclusion that post-modern research paradigms' legitimacy has been established, and that this legitimacy is at least equal to that of the positivist tradition. Eisner (1997) has argued that in social sciences research methods are socialised. He further explained that this socialisation of research methods influences our view of what we consider to be of value, and what we can discover. The lesson from Geertz (1988) was from the observation of the increasing blurring of the traditions. It is largely for these reasons that this study is not located in one epistemological position. This multi-epistemological approach in turn resulted in my adoption of multiple methods (documentary analysis, grounded theory, and questionnaire survey). These are discussed in chapters 4, 5, and 6 respectively.

### **3.2 Overview of Study Design**

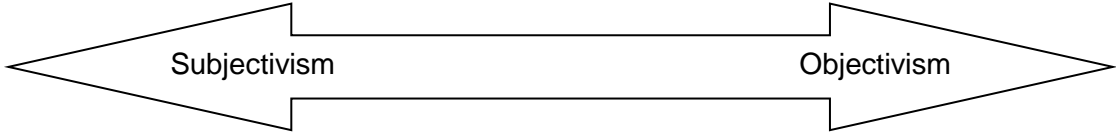
- 3.2.1 The research was a 3-stage exploratory, descriptive, and explanatory study (see *Figure 3a*). It adopted a sequential (Teddle and Tashakkori 2003; Creswell 2009) multiple methods approach (Morse 2003). The design

involved qualitative and quantitative projects, which were relatively complete in their own right. In addition to Creswell *et al.* (2003), and Creswell (2009) have provided a very useful checklist of 12 items, which was essential during the process of the study design (see *Appendix 3a*). In addition to this checklist I found the three factors for determining the multiple methods study design identified by Byrne and Humble (2006) very useful. The first factor regards the approach to the implementation of data collection. This can either be sequential or concurrent (Creswell 2009). In an '*explanatory sequential multiple method research design*' quantitative data is collected and analysed before qualitative data is collected in order to contextualise the statistical data (Byrne and Humble 2006). On the other hand in an '*exploratory sequential multiple method research design*', qualitative data is collected in order to explore a phenomenon or phenomena and then quantitative data is collected with the aim of explaining the relationships observed in the exploratory phase of the research (Byrne and Humble 2006). This current study is the later. The second factor regards how the qualitative and quantitative elements of the study are prioritised (Morse 2003; Creswell 2009). A multiple method research design can either have a deductive, or an inductive theoretical drive. This research has predominantly an inductive theoretical drive and has a QUAL → quant notation (Morse 2003; Creswell 2009). Details of, and rationale for the documentary, grounded theory, and questionnaire survey stages of the study are discussed in chapters 4, 5, and 6 respectively. The third factor deals with how the research is integrated. Byrne and Humble (2006) have identified four considerations, which I found useful (research purpose, purpose of each stage / study, researcher's views, and simplicity of integration). In this study,

in some way, integration took place at each stage because each of the subsequent stages was informed by the findings of the preceding stage. However, the overall integration of the study findings occurred in the write-up of the thesis in chapters 10, 11, and 12.

3.2.2 An examination of the literature revealed a somewhat unclear, and interchangeable use of terminology regarding '*methods*', and it is therefore prudent to address this at this point in order to make it as clear as possible what I refer to as 'methods' and 'methodology' in this study.

Figure 3a: Study design (based on Crotty 1998).

Exploratory sequential multiple methods				
QUAL→quant Notation (Morse 2003)				
Epistemological continuum				
		Stage 1 (Exploratory phase)	Stage 2 (Descriptive phase)	Stage 3 (Explanatory phase)
Theoretical perspective		Interpretivist	Interpretivist	Positivist
Methodology		Documentary (Bailey 1994)	Grounded theory (Glaser & Strauss 1967; Glaser 1978)	Survey (Brehin & Sidell 2000)
Methods	Method	Documentary analysis	Semi-structured interview	Online survey questionnaire
	Participants	Job descriptions Person specifications	Learning disability nurse consultants & other senior NHS nurses in LD practice	Community learning disability nurses
	Sampling	Purposive (Glaser & Strauss 1967; Wilmot 2005)	Purposive + Theoretical (Glaser & Strauss 1967)	Non-proportional quota (Punch 2003; Morrow <i>et al.</i> 2007)
	Data analysis	Content / Thematic Nvivo8 (Holsti 1969; Neuendorf 2002)	Constant comparative / Thematic Nvivo9 (Glaser & Strauss 1967)	Descriptive / Inferential statistics SPSS19 (Pallant 2007; Hinton <i>et al.</i> 2004)



3.2.3 What I realised was that the words '*methods*' and '*methodology*' were used incorrectly and interchangeably (Tashakkori and Teddlie 1998). There are three connotations of the term methodology that appear in literature. The first connotation appears in the work of Gomm (2008), and is used generally to refer to the study of research methods. The second usage of the term appear in the work of Miles and Huberman (1994), and is used to describe generalisations of specific research methods, and an example of this is what is given as '*methodology*' (documentary, grounded theory, survey) in *Figure 3a*. These methodologies are sets of less prescriptive but structured *a priori* guidelines essential in ensuring validity and reliability of research. The third connotation appears in the work of Tashakkori and Teddlie (1998) and is used to describe a specific methodology of a specific research project. In other words this refers to the actual research methods such as documentary analysis, semi-structured interview, and online survey questionnaire (see *Figure 3a*).

### **3.3 The research paradigm divide**

3.3.1 In order to fully appreciate the role of research paradigms, it was important for me to explore and evaluate the enduring paradigmatic debates. According to Kuhn (1970), particular combinations of assumptions are called paradigms, and paradigms may not coexist. However, I agree more with the alternative view of Burrell and Morgan (1979) who has suggested that paradigms could co-exist in social research. According to Tashakkori and Teddlie (1998), a paradigm is a theoretical construct that outlines a set of philosophical assumptions at the cosmological (worldview), ontological (existence), epistemological (knowledge), axiological (ethical), methodological, and

methods levels. I observed that a number of paradigms exist, but authors differ on how they describe the underlying dimensions. This lack of a consensus of the underlying dimensions of paradigms proved challenging to me in deciding where to locate this study. All literature identified the two most dominant paradigms, positivist (objectivist, functionalist, empiricist), and interpretivist (subjectivist, constructivist) (Lee 1991; Guba and Lincoln 2005; Denzin and Lincoln 1994). A number of authors identified three other paradigms; functionalist, humanist, and structuralist (Burrell and Morgan, 1979), or normative, critical, and dialogic (Deetz, 1996). What is clear from the literature is the inability of any of the paradigms to be all encompassing. This situation was quite significant in my adoption of a multiple methods approach.

3.3.2 The final decision rested on how well the chosen paradigms could help me in answering the questions I was seeking answers to. This approach is consistent with Hallawell (2006). Based on this approach my decision was to locate the study within the interpretivist-positivist paradigmatic continuum (see *Figure 3a*).

3.3.3 Positivism as a research concept originated in the early part of the 19<sup>th</sup> century, and was developed by the French sociologist and philosopher Auguste Comte. It is synonymous with the scientific method, empiricism, and quantitative methods. Since then other philosophers have sought to refine this approach. Of note in this is the work of Karl Popper (1963) on what he called empirical falsification. In Popper's approach a hypothesis is one, which can be proved to be false (Popper 1963). The central tenets of positivism are that truth is singular and fixed, and that research has to be objective, reliable,

valid, generalizable, and reductive / deductive (Burns 2000). I consider this to be a very narrow view of the world and inconsiderate of the social complexities that exist. I noted that Burns (2000) has argued that there are four fundamental characteristics of the scientific method, and that is, control, operational definition, replication, and hypothesis testing. However, Gartell and Gartell (1996) have argued that the most important characteristics of the scientific method are clarity, replicability, reliability, and validity. I found this lack of consensus quite unhelpful in evaluating the virtues of the scientific method, and this rather emphasises my rationale for opting for a multiple method approach in this study. In my efforts to place elements of my research in this paradigm, Guba and Lincoln (2004) provided a useful overview through their conclusion that positivism asserts that knowledge could only be generated through splitting reality into objects and subjects. My view is that realities go far beyond that. In addition, Guba and Lincoln (2004; 2005), and Burns (2000) have noted an increasing realisation, and acceptance by positivists that it is futile in social research to separate researchers from the research process. They have argued that researchers consciously or unconsciously become actors in their own research (Guba and Lincoln 2005). Furthermore, Burns (2000) has noted that positivism ignores that the study of human beings is much more complex than studying inert objects for which the positivist tradition was developed. In addition, Guba and Lincoln (2004, p.19-20) highlight a number of internal criticisms such as;

*'...context stripping, exclusion of meaning and purpose, disjunction of grand theories with local contexts, inapplicability of general data to individual cases, exclusion of the discovery dimension in inquiry'*), and extra-paradigmatic criticisms (*'the theory-ladenness of facts, the under-*

*determination of theory, the value-ladenness of facts, the interactive nature of the inquirer-inquired'.*

Despite all these limitations I found that positivism was important in the explanatory phase of this study for a number of reasons. Firstly, the study needed to establish and measure relationships between variables of role enactment. This could only be achieved through this approach. In addition, the deductive approach inherent in positivism allowed for statistical analysis (Burns 2000), and this was necessary for the explanatory phase of this study. Furthermore, the use of quantitative data inherent in positivism allows for descriptive and inferential statistical analysis, which was also important in the explanatory phase of this study.

3.3.4 Alternatively interpretivism, which is one of the most widely accepted research paradigms (Kim 2003) is useful in capturing the social complexities associated with a study of this nature. However, qualitative data;

*'...can only provide a partial account and may require to be supplemented by other data' (Morgan et al. 2002, p.18).*

Interpretivism looks at people's subjective realities (Holloway and Wheeler 1996), and is idiographic, anti-positivist, hermeneutic, and inductive (Hayes 2000). It is useful in areas where there is little known about a phenomenon under investigation. This was the case at the commencement of this study in that there was very little known about how community learning disability nurses enact their public health roles. Boarder (2002) has observed that there was negligible research into the public health roles of community learning disability nurses. In a review of literature, Mafuba (2009) has noted that there was a lack of in-depth studies that evaluated and validated the public health

roles of learning disability nurses. For these reasons it was appropriate to locate a significant part of this study within interpretivism.

3.3.5 According to Strauss and Corbin (1990), interpretivism is broadly defined as any research that arrives at findings through the process of induction and not arrived at by means of statistical or quantitative analyses. Denzin and Lincoln (2005a) have noted that there are many traditions of qualitative enquiry. Given my ontological position discussed earlier, it was challenging when I found that interpretivism has its origins in sociology and anthropology during colonisation at the beginning of the twentieth century (Smith 1999; Vidich and Layman 2000).

3.3.6 Discovering that qualitative inquiry is such '*...a complex, interconnected family of terms, concepts, and assumptions...*' (Denzin and Lincoln 2005a, p.2) was quite challenging in some way. Denzin and Lincoln (2005b) identified pragmatism and naturalism used in American sociology, anthropology, communications, and education; French and German phenomenology, hermeneutics, semiotics, Marxism, and feminism (Denzin and Lincoln 2005b). Given my ontological position I discussed earlier, my position here is pragmatic. The underlying assumption of interpretivism is the need to examine the whole in order to understand phenomena. In addition, interpretivism asserts the existence of temporal and spatial multiple realities. An examination of the literature on interpretivism reveals that there is no overarching framework for how research is conducted. In a research project the researcher is guided by their philosophical positions in adopting appropriate methodologies in order to investigate phenomena. Although at the

beginning the existence of so many approaches was daunting and confusing, the work of Denzin and Lincoln (2005a) was very useful in helping me to adopt the approaches I used in the exploratory and descriptive phases of the study.

3.3.7 According to Flick (2002), and Nelson *et al.* (1992), because of the absence of an overarching framework, qualitative research is fundamentally multi-paradigmatic and multiple method in nature. Flick (2002) has also noted that because of a lack of an agreed framework, qualitative research embraces both the broad postmodern stance, and at the same time becomes drawn towards narrow positivist analysis of human experience. This analysis was rather poignant in my own search for a methodology to address the exploratory, and descriptive stages of the study. There are a number of criticisms and limitations of interpretivism that I needed to take account of in designing this study. Denzin (1997), and Huber (1995) have cited the historical and present liaison between interpretivism and politics as one of its greatest limitations. Both authors also cite the inability of interpretivism to identify a hypothesis as a significant limitation. Denzin (1997) has argued that lack of clearly defined variables and '*hard evidence*' form one of the basis for arguments against qualitative research. Seale *et al.* (2004, p.2) further criticised the anti-methodological stance of interpretivism and characterised it as an '*anything goes*' approach that over-romanticise postmodernism. Burns (2000) cites difficulties with validity, reliability, lack of replicability, lack of generalizability, and;

*'...time required for data collection, analysis and interpretation'* (p.13),

as the main limitations of qualitative research. Furthermore, Parlett (1975) has argued that the interaction of the researcher and the researched removes anonymity, and introduces bias, which affect results of any outcome. Despite all these challenges and limitations, there are advantages, which were of immense value to this study.

3.3.8 Guba and Lincoln (2004) have identified a number of advantages of qualitative research that emerged from their rebuttal of its intra-paradigmatic critiques, which I found to be reasoned and rational. They identified contextualisation of information, provision of meaning, purpose, and insight into human behaviour, applicability of findings to individual cases, and exploration of sources of hypotheses as some of the advantages of qualitative research (Guba and Lincoln 2004). These views were particularly useful in the exploratory and descriptive stages of this study. I found another strength of qualitative research in the work of Barton and Lazarsfeld (1969) when they highlighted its potential to reveal unexpected results. Finally, Meyer (2000) extolled the richness, depth of explorations, and descriptions that are possible with qualitative research. All these authors significantly influenced the study design for this research project.

3.3.9 The positivist-interpretivist debate about methodologies has thus far focused on rigor, relevance, generalizability, reality, and validity. However to me this situation is purist and unhelpful (Silverman 1993). My own view is that a chosen method must be that capable of producing the best account of the phenomenon under investigation (Hallawell 2006). Given inadequacies of each of the two major paradigms of research highlighted above, a multiple

methodology approach was the most viable option capable of generating useful findings in this study. This position is also consistent with Bryman (1988) who has argued that there is much to be gained from using multiple methods. Furthermore, the goals of the research needed to influence the choice of methods used, taking into account my cosmological, ontological, and epistemological positions as a researcher (Hayes 2000; Baum 1995). Casebeer and Verhoef (1997) have further argued that complex investigations in health, and social care could be properly addressed through adopting a triangulated, and flexible approach to research.

### **3.4 Multiple methods**

- 3.4.1 Denzin and Lincoln (2008) have suggested that the use of multiple methods is useful in securing a deeper understanding of phenomena under investigation. Furthermore, Halcomb and Andrew (2005) have provided a detailed and very useful analysis of the extent and value of multiple methods in nursing research. In addition to the discussion I have engaged in thus far, there are several other reasons why I located this study within more than one paradigm. Firstly, I realised that it was impossible for one research method to be able to provide a holistic view of the complex phenomenon that was under consideration (Burr 1996; Holloway and Wheeler 1996; Cowman 1993; Sandelowski 2000). In addition, according to Shih (1998) triangulation is fundamental in the confirmation of phenomenon under investigation. I needed to explain the observations I made in stages 1 and 2 of the study. Furthermore, I realised that it was impossible for positivist acquired data in stage 3 of the study to capture the context and social complexities associated with research on experience and perception of community learning disability



nurses (Sayer 1992; Hammersley and Atkinson 1995). Finally, Denzin (1970) has noted that triangulation increase validity, strengthens the interpretative potential of a research study, and reduces investigator biases. This meant that locating this study solely within a traditional scientific paradigm would not have been appropriate.

3.4.2 The use of multiple methods in a single study has been around in social research for sometime (Campbell and Fiske 1959; Erzberger and Prein 1997). There has been recent growth in multiple methods research studies (Greene *et al.* 2001) including in nursing. Campbell and Fiske (1959) who are credited with introducing multiple methods noted that triangulation enhanced validity through data confirmation (Begley 1996; Coyle and Williams 2000). In addition, multiple methods are considered to be useful in shedding light on the phenomena under investigation from different viewpoints (Fielding and Fielding 1986; Begley 1996; Coyle and Williams 2000). Furthermore, I found the argument by Halcomb and Andrew (2005, p.73) that triangulation at the epistemological level provides a '*completeness of understanding*' of the phenomena. I considered this view to be rational and reasoned. Role perceptions of community learning disability nurses were a central element of stages 2 and 3 of this study. Multiple methods are appealing when investigating perceptions and experiences (Darbyshire *et al.* 2005; Brechin and Sidell 2000). Holman (1993) has noted that qualitative and quantitative methods compliment each other in healthcare studies. The literature presented here suggests that using a multiple method approach for this study was more likely to generate valid and reliable knowledge than a single method approach.

3.4.3 As stated earlier, my position is that a research issue needs to influence the methods employed, rather than just the researchers' philosophical positions (Niglas 1999). In my opinion, multiple methods research designs need to be used when the need arises (Maxcy 2003). My decision to use multiple methods was also influenced by the argument put forward by Greene and Caracelli (2003) that paradigms are a result of social construction and therefore not set in tablets of stone. In essence, as a researcher I had to locate the study within current philosophical boundaries as I saw fit. It turned out in literature that philosophical boundaries exist at the theoretical level and they tend to get blurred in practice (Goodwin and Goodwin 1984). Goodwin and Goodwin (1984) have further suggested that the use of qualitative and quantitative approaches in one study was appropriate, pointing to the fact that methods are not necessarily aligned with specific paradigms. Furthermore, Brechin and Sidell (2000) have pointed out that methodological boundaries in a study of this nature are complex and lack clarity. Using multiple methods at both the philosophical, and methodological levels (see *Figure 3a*) to me was essential in enhancing clarity and the richness of the data I collected in all the 3 stages of the study. As Brechin and Sidell (2000) further pointed out, any effort to make philosophical boundaries absolute was only going to oversimplify '*complex moral, philosophical and political belief systems....*'(p. 7) within which this study took place.

3.4.4 Other authors also support the use of multiple approaches in a single study, for example, Mitchell (1986). The author has argued that multiple methods provide opportunities for differing approaches to complement each other,

thereby enhancing reliability and validity of the findings of the phenomenon under investigation.

3.4.5 The work of Byrne and Humble (2006) has been useful in highlighting the benefits of multiple data collection methods. They suggested that multiple methods could be exploratory, descriptive, or explanatory (as in this study), thereby allowing the researcher to construct, explore, describe, explain, and confirm a theory within the same study (Byrne and Humble 2006). Combining qualitative and quantitative methods was therefore useful in strengthening the study (Bowling 1997), and enhanced its validity and its relevance (Salomon 1991). In addition, I discovered that multiple methods offered me opportunities to look at the phenomenon from the three different angles (Holloway and Wheeler 1996).

3.4.6 At this point it is important to highlight the broad challenges highlighted in existing literature regarding triangulating studies that I needed to consider during the design and conduct of this study. It is important to note that the limitations of the qualitative and quantitative methodologies are not necessarily completely eliminated in a triangulated study design. What I have observed is that research paradigms are located in differing cosmological, and ontological realms, and it is understandable that many researchers find it difficult to hold differing beliefs at the same time (Nagle and Mitchell 1991). However, Copnell (1998) has commented that in using multiple methods researchers were assuming that choosing a research approach is only technical, and ignores ethical, ideological, and political realities. This was an important point for me because any knowledge generated needed to fit within

a theoretical framework. This point has been generally addressed in this chapter, and will be further discussed in section 4 of this thesis.

3.4.7 What became clear from the beginning of the study was the lack of a framework, and the limited amount of information regarding how multiple methods studies could be implemented (Corner 1991). As likely to be with many other researchers, and with hindsight, there was some degree of naivety and a lack of understanding on my part regarding the extent of the complexity of implementing multiple methods studies (Halcomb and Andrew 2005; Dootson 1995). Begley (1996), and Thurmond (2001) have noted that in many cases triangulation is used to increase the volume of data without consideration of how data would enhance validity, reliability, and rigour of the results. What also became clearer as this study developed was the complexity and extent of the work involved at every stage of the study. Putting the design together was quite challenging in itself. In addition, careful consideration had to be made to ensure that the study demonstrated integrity and coherence all the way from the epistemological drive right down to data interpretation and writing up of this thesis. A good example of what I am referring to here is that the study employed three different methods, and all these had to be considered in their own right resulting in the need for three separate chapters on methods and three separate chapters on results. Another important drawback of multiple methods for me is that it turned out to be resource intensive in terms of expense, time, and researcher skills (Nolan and Behi 1995; Shih 1998; Thurmond 2001). In the end this study was only possible because my employer agreed to meet fairly significant expenses on subsistence during stage 2 of the study and on the acquisition of different data

analysis software that I needed. Stage 2 of the study involved semi-structured interviews across the whole of the UK, and this was time consuming. In addition, interview transcription was time consuming. At the beginning, this study was a 4-stage design with stage 4 involving focus groups with service users of public health services who have learning disabilities. During stage 2 it became clear that the study was going to take too much time and would eventually become unmanageable. After consultation with my supervisors a decision was made to translate stage 4 into a post-doctoral study. In terms of researcher skills, this was also a challenging undertaking (Thurmond 2001). In all I had to develop sufficient depth of knowledge of three methodologies, three methods, two sampling methods, three data analysis methods, and three different types of data analysis software. Another potential disadvantage of multiple methods is that because of the extent of the work involved, there could be a limit placed on the depth of error and bias checking for each of the procedures (Begley 1996; Dootson 1995; Nolan and Behi 1995). Another potential difficulty, which I had to consider carefully from the onset, was what route to take in the event that findings from the three stages were completely divergent (Proctor 1998). There were two contingencies to this potential eventuality. The first, and most important was built into the study design itself (Proctor 1998). Each of the stages was designed as an independent study in its own right with separate methods and separate presentation of results. This would allow the results to be reported and discussed separately even if the results failed to converge. The second contingency would involve the synthesis of the potential sources of the lack of convergence (Chelsea 1992). As it turned out this was not necessary and because the results were

convergent. As a result the study was integrated in the discussion section of this thesis.

3.4.8 An examination of existing literature has revealed a wide variation in the language used in multiple methods studies. These include multi-method, mixed methods, multiple methods, and triangulation (Denzin 1962; Creswell *et al.* 2003; Morse 2003; Teddlie and Tashakkori 2003; Byrne and Humble 2006; Creswell 2009; Barbour 1998; Greene and Caracelli 1997; Polit and Hungler 1995). In this thesis the terms '*multiple methods*' and '*triangulation*' are used. The term multiple methods is used in the context of the study design (Shih 1998), and triangulation is used in the context of the process of implementing the methods (Thurmond 2001). Denzin (1962, p.294) has defined multiple methods as the triangulation of '*...method, investigator, theory, and data*'. He further argued that triangulation is the '*...soundest strategy of theory construction*' (p.294). This approach to defining multiple methods was quite significant for me in that it proposes triangulation at the epistemological, methodology, and methods levels. What I also found useful was the description of multiple methods research as studies that obtain data from multiple sources, and use multiple analyses (Jacobs 2005; Teddlie and Tashakkori 2003; Creswell 2009). What was of interest in this approach to me was the '*concurrent*' or '*sequential*' design of multiple methods research (Creswell 2009). The sequential design of the current study was informed by this view and is discussed in more detail later in this chapter. There are two lessons from Morse (2003) that are important in how I designed, and undertook this study. The first is that each stage within the study was designed to answer a specific sub-question, which was part of the whole

(Morse 2003). The second lesson from Morse (2003) as well as from Creswell (2009) was the description of notations used to describe the theoretical drives of research projects. At this point it would be appropriate to examine literature regarding the types of triangulation. In addition, it is also useful to explain and provide a detailed rationale for each of the type of triangulation applied in this study.

3.4.9 Examination of current literature revealed that there are six types of triangulation (theoretical, methodological, data source, multiple, investigator, analysis) (Denzin 1970; Boyd 2000; Thurmond 2001; Banick 1993; Mitchell 1986). The types of triangulation adopted for this study are outlined in *Figure 3a*. As can be seen from *Figure 3a*, investigator, multiple, and analysis triangulation were not specifically adopted for this study and are therefore not discussed here. As can be seen from the research design in *Figure 3a*, this study had a multi-epistemological approach. This was broadly discussed in chapter 3 of this thesis, and therefore will not be discussed any further here.

3.4.10 The first triangulation I considered for this study was theoretical triangulation.

Theoretical triangulation is the use of multiple theories or hypotheses to investigate a phenomenon (Mitchell 1986; Murphy 1989; Denzin 1970; Corner 1991; Kimchi *et al.* 1991; Cowman 1993; Nolan and Behi 1995; Shih 1998). Denzin (1970), and Banik (1993) have further explained that theoretical triangulation looks at testing opposite theories. In this study the two theories considered were the effects of role clarity, and role ambiguity on role enactment. The process of theoretical triangulation can involve the same data set, or different data sets (Boyd 2000). In this study I triangulated different

data sets. This was in order to pre-empt and address the possibility of none convergence of data. According to Thurmond (2001), and Banik (1993) theoretical triangulation is useful in providing a broader and deeper analysis of findings by looking beyond obvious findings. Furthermore, the explanation by Mitchell (1986) who highlighted the benefits of theoretical triangulation in reducing the amount of explanations of a phenomenon was quite useful for me.

3.4.11 Despite all the benefits of theoretical triangulation highlighted here, there are limitations, which I had to bear in mind during the design and implementation of this study. Firstly, according to Burns and Grove (1993), theoretical triangulation can result in poor studies if the rationale for using it is not clearly defined at the beginning of the project. Secondly, according to Banik (1993) analysing the data, and the resulting interpretation of the concepts could be difficult. Lincoln and Guba (1985) have identified two potential disadvantages of theoretical triangulation. They argued that triangulation could be epistemologically faulty if this was not clarified (Lincoln and Guba 1985) at the beginning. They also noted that findings could be difficult to interpret if the underlying constructs and concepts were the same or overlapped (Lincoln and Guba 1985). In my efforts to address these potential limitations I clearly defined all my approaches from the philosophical underpinnings as well as how data would be analysed right from the beginning of the project.

3.4.12 The second triangulation considered for this study was methodological triangulation. The literature examined shows that methodological triangulation is more complex and confusing (Goodwin and Goodwin 1984). The main



confusion seemed to arise from that it is used to describe triangulation at either the design, or data collection levels (Goodwin and Goodwin 1984; Lincoln and Guba 1985; Mitchell 1986; Kimchi *et al.* 1991; Morse 1991; Brannen 1992; Cowman 1993; Begley 1996; Murphy 1989; Shih 1998). In literature, methodological triangulation is discussed in the context of qualitative and quantitative study design (Lincoln and Guba 1985; Mitchell 1986; Barbour 1998; Greene and Caracelli 1997; Cobb 2000). Other authors refer to qualitative and quantitative data collection methods, analysis, and interpretation of results (Goodwin and Goodwin 1984). In addition to discussing methodological triangulation from study design and data collection perspectives, it is also further divided into within-method triangulation, and between-, or across-method triangulation. In the within-methods approach at least two data collection strategies (both qualitative or both quantitative) from the same paradigm are used in studying the same phenomenon (Corner 1991; Kimchi *et al.* 1991; Nolan and Behi 1995; Begley 1996; Thurmond 2001). On the other hand the across-methods approach uses a mix of qualitative and quantitative strategies to measure the same variable (Denzin 1970; Mitchell 1986; Corner 1991; Kimchi *et al.* 1991; Nolan and Behi 1995; Begley 1996; Boyd 2000; Thurmond 2001).

3.4.13 I have already noted that methodological triangulation has several advantages. According to Dzurec and Abraham (1993), the broad purpose of qualitative and quantitative studies is the same in that they seek to gather evidence, or generate new knowledge. Therefore, in this study combining methods within the same paradigm was possible, and sensible in order to have a clearer picture from both worldviews (Lincoln and Guba 1985). I also

noted the conclusion made by Wilson and Hutchison (1991) that combining qualitative and quantitative approaches is useful in providing the scope and detail essential in nursing research. Another advantage of methodological triangulation I found attractive is that it has potential to compensate the weaknesses of one method with the strengths of the other (Morse 1991; Corner 1991; Morgan 1998; Thurmond 2001). According to Morse (1991), this is particularly useful when combining interview data with survey data. This view was particularly useful in informing the design of this study for stages 2 and 3.

3.4.14 Methodological triangulation is not without its critics. It was important for me to be aware of their criticisms. Some critics have argued that qualitative and quantitative approaches differ fundamentally at the ontological and epistemological levels that it is impossible to combine the two in one study (Dzurec and Abraham 1993; Polit and Hungler 1995). However, in this study the 3 stages were relatively independent of each other, and each method was rigorous, and robust enough to be sustainable on its own (Morse 1991). I also needed to be aware of the warning made by Fielding and Fielding (1986) that data errors from one approach could not be compensated by accuracies in another approach. Polit and Hungler (1995) have also warned of increased cost; lack of researcher expertise in both qualitative and quantitative approaches; and challenges of integrating qualitative and quantitative results. In this study the results for each of the 3 stages are reported separately with integration occurring in the discussion of the thesis.

#### 3.4.15 The third triangulation I used in this study occurred at the data source level.

Data triangulation refers to the use of multiple sources of data used to explore the same phenomenon (Mitchell 1986; Murphy 1989; Kimchi *et al.* 1991; Cowman 1993; Nolan and Behi 1995; Begley 1996; Shih 1998). In addition, the triangulation of data could be in the context of time (Denzin 1970; Kimchi *et al.* 1991), place (Mitchell 1986; Kimchi *et al.* 1991), and person (Denzin 1970; Kimchi *et al.* 1991). In this study the time and place were not of interest, therefore these are not explored any further. What was of interest was data source triangulation in the context of the participants. In this approach to data source triangulation, data was collected from more than one level of participants involved in the phenomenon under consideration (Denzin 1970; Kimchi *et al.* 1991; Brannen 1992; Begley 1996). In this study data source triangulation involved three different sources (employers by proxy through job descriptions and person specifications; learning disability nurse consultants and others; and community learning disability nurses).

3.4.16 Triangulating data at '*participant*' level presented a number of advantages, which were an important consideration for this study. Triangulating data was important in increasing the volume of data (Banik 1993). In addition, triangulating the source of data was important in enhancing confidence levels in the data (Fielding and Fielding 1986). Improving confidence levels is important in any study, whether it is qualitative or quantitative because it enhances the validity and reliability of the findings. In this study job descriptions and person specifications were used to explore how public health policy was interpreted and translated into job roles by employers. In the descriptive phase of the study, learning disability nurse consultants and others

were interviewed to explore further the findings from the exploratory phase of the study. In the explanatory phase of the study a wider, and larger group of community learning disability nurses was surveyed using an online questionnaire in order to explain correlates of public health role enactment. The large volume of data collected was useful in enhancing confidence in the data, validity, reliability, rigour, and ultimately in the overall findings.

3.4.17 Data triangulation is not without challenges. Firstly, in carrying out this study there was a large amount of data which although it was essential in enhancing confidence levels; handling, analysing, and interpreting such large amounts of data had potential for errors which could have resulted in wrong interpretation of the findings (Porter 1989; Thurmond 2001). To militate against this potential I handled each data set separately. In addition findings were repeatedly checked against the data. Furthermore, my supervisors acted as independent reviewers and repeatedly reviewed the data. Secondly, to ensure comparability of data across the three stages of the study, I had to decide on a key unit of data categorisation that would be common and representative across all three stages (Parahoo 2006). This was important in deciding on the core biographical data collected (Cresswell and Clark 2006). In addition, the key unit of data categorisation was important in the analysis of data across the three stages of the study.

3.4.18 As mentioned earlier, multiple methods can either be concurrent or sequential. This study adopted a sequential approach, and at this point I will explain my rationale for the use of the sequential multiple methods in this study.

### **3.5 Sequential multiple methods**

3.5.1 Sequential multiple methods involve the use of results obtained through one method of data collection to determine the direction and implementation of the following stage of the research (Morse 1991; Morgan 1998). In this study the appropriateness of each approach at each stage was influenced by the research questions and the rationale for using each data collection method. Although many authors in the literature reviewed advocated for the use of multiple methods, most of these were silent on the practical implementation of such approaches. Powers (1987) has argued that since the aim of multiple methods was to obtain data that is complimentary, a sequential approach ensures that all relevant data is collected. This approach was invaluable in that it allowed me to be able to make adjustments and refine each subsequent stage following findings from the preceding stage.

3.5.2 My understanding of the value of multiple methods in practice was further aided by the work of Brechin and Sidell (2000). They created a three '*lenses*' framework of '*knowing*', which was a useful approach in articulating, and operationalizing this complex research. The fact that these lenses could be used sequentially or concurrently fitted very well with the overall sequential multiple methods research design that I adopted. Applying the first lenses to this study was useful in looking at the importance of how capacity for prediction and control (positivist) could be improved. Brechin and Sidell have further argued that knowledge creation should be free of subjectivity, need to be objective and systematic (Brechin and Sidell 2000). In stage 3 of the study I employed the use of a survey questionnaire to verify the themes that emerged from stages 1 and 2 with a larger group of community learning

disability nurses. It was therefore of necessity that stage 3 of the study was located within a deductive positivist approach to test the theories that would have emerged thus far. Layder (1993) has explained that only hypotheses, which have emerged from theory, could be tested in order to reject or accept them. In brief it was necessary that stage 3 of this study be concerned with testing the relationships between the correlates of role enactment that emerged from stage 2 of the study.

3.5.3 I also found the second lenses to be useful because it enabled me to focus on developing an understanding and exploration of meanings (Brechtin and Sidell 2000) in stage 2 of the study. As said earlier, this study adopted a predominantly inductive theoretical drive with a QUAL→quant notation (Morse 2003). Stages 1 and 2 were devoted to theory generation (Glaser and Strauss 1967; Layder 1993). Parahoo (2006) has further highlighted this point when he explained that most theories emerge from what is already known. According to Glaser and Strauss (1967), theory generation is crucial in creating knowledge. They have argued for the need for inductive research to be seen as a preliminary stage in a project, and they saw this process as more capable of producing relevant propositions. They also argued that findings obtained through the inductive process need to be tested quantitatively later. What was perhaps even more important for me was their positivist stance that prediction and control are important in explaining behaviour (Glaser and Strauss 1967). This emphasises a view that a sequential multiple method approach to social research is useful and important in generating relevant knowledge.

3.5.4 The third lenses suggest that research could be viewed as a method of promoting social values (Breachin and Sidell 2000). Lairumbi *et al.* (2008) have argued that research needs to make contributions to the values of the society in which it is undertaken. This was important in this study because translating research into policy and practice is difficult and complex (Lavis 2006). The implications of this are that research undertaken ethically, and which promotes society's social values is more likely to inform and influence policy and practice. In this study the research undertaken involved how community learning disability nurses enacted their public health roles in implementing public health policy for people with learning disabilities. It could therefore be argued that this research has significant societal value for people with learning disabilities.

### **3.6 Ethical considerations**

3.6.1 Ethical considerations based on the morality of individual autonomy have been an important element of social research since the work of Mill (1893) in the 19<sup>th</sup> century. Of interest to me in Mill's work is the need for research participants to be properly informed about the purpose and potential negative consequences of participating in research. The notion of the right of a research participant to give informed consent was further developed in the work of Weber (1949). Understanding ethics was important in this study for two important reasons. Firstly, the UK NHS has had a *Research governance framework for health and social care* since 2001 (DH 2005a). This study involved the participation of NHS staff, and as such I had to obtain ethical approval in order for it to take place. The original study design was for a 4-stage study and initial approval was for stages 1 and 2 (see *Appendix 3b*).

After completing stages 1 and 2 further approval was sought, and granted for stage 3 (see *Appendix 3c*). In addition, and I think more importantly, undertaking research is inherent in my professional practice and I had to undertake this research within the ethical boundaries of my professional practice. For a clearer understanding of the code of ethical practice I turned to Christians (2005), Hek and Soteriou (2003), Gillon (1994), and Burns (2000) who provided useful principles based guidelines. Of importance to me in this framework was the need to ensure informed consent, maintain privacy and confidentiality of participants, and ensure accurate reporting of the findings.

- 3.6.2 It was important for me to provide necessary information to participants, and obtain consent (Soble 1978) (See *Appendices 3d and 3e*). Stage 1 of the study involved the collection of non-personal information that was freely available to the public so there were no consent issues. In stage 2, in addition to the consent information being e-mailed to the participants in advance of the interviews, verbal consent was sought and recorded at the beginning of each interview. In stage 3, data was collected online. The guidance and consent information was sent in advance electronically via e-mail to all potential participants. In addition, the same information was built into the first page of the online survey questionnaire (see *Appendix 6a*). It was also important to maintain the privacy of all data collected at all stages of the study in order to avoid unwarranted, and unwanted exposure of the participants (Christians 2005). No personal data that could lead to identification of any participant was collected. All data was anonymised by use of codes from the point of collection. The final lesson I got from



Christians (2005) was the need to ensure accurate reporting of the findings. Finally, I also consulted Reynolds (2006), and Tod *et al.* (2009) regarding preparation of documents required for ethics approval application.

### **3.7 Conclusion**

3.7.1 In this chapter I have explored the relevance of cosmology, ontology and epistemology in the overall design of this study. I have highlighted my rationale for adopting a 3-stage exploratory sequential multiple methods approach to this study. I have also highlighted the ethical considerations taken in designing and undertaking the study. In the next chapter I explain and rationalise the documentary method I used in stage 1 of the study.

## **Chapter 4: Stage 1 – Documentary Analysis (exploratory phase)**

### **Introduction**

This chapter begins by outlining and rationalising the documentary method. This is followed by a brief discussion of the use of documents used in this exploratory phase of this study. The following section explores purposive and theoretical saturation approaches used in sampling. Issues related to data handling and data preparation for analysis are then explored, followed by an overview of how data was analysed including sorting processes and coding. The last section in this chapter looks at the validity and reliability issues of the documentary method.

### **4.1 The documentary method**

- 4.1.1 This stage of the stage of the study focused on answering subsidiary question (a) (see page 2). The aim was to explore how public health policy was reflected in community learning disability nurse's job descriptions and person specification. In addition the study explored how such policies were translated into roles. According to Bailey (1982, 1994), the documentary research method regards the analysis of documents that contain useful information that is pertinent to the phenomenon under consideration. Tim May has noted that many social researchers consider documents to be a representation and reflection of social realities (May 2001). In addition, Payne and Payne (2004) have noted that the documentary method involve the use of private or public documents. In this study the documents examined were job descriptions from

statutory NHS organisations. These are considered to be official public documents.

4.1.2 Documentary analysis has been widely used in the analysis of health and healthcare policy implementation in the UK (Abbott *et al.* 2004). In recent times the English Department of Health has commissioned policy implementation research on a large scale (Mays *et al.* 2001; Regen *et al.* 1999; Sibbald *et al.* 2002; Abbott *et al.* 2001; Shaw *et al.* 2002).

4.1.3 There are a number of ways documentary analysis could contribute to our understanding of policy implementation that were of interest to me in adopting this method. According to Mason (1996) documents can be a source of information on processes being undertaken by the government on particular issues such as implementing public health policy for people with learning disabilities. Scott (1990) has noted that documents fall into one of four categories, that is; open and published, open and archived, restricted, and closed. In this study the documents were open and published on the worldwide web. The NHS and other statutory organisations produce and publish large volumes of documents, including job descriptions. These documents are readily available, and inexpensive to collect (Appleton and Cowley 1997; Peters 1998; Lincoln and Guba 1985). In addition, because the documents were readily available electronically, it was easier and quicker to collect and analyse the documents (Abbott *et al.* 2004; Lincoln and Guba 1985) without need for further processing. Furthermore, the documents collected were in the public domain, thereby eliminating the need for consideration and negotiation of ethical issues (Hodder 1994). Importantly, the collection of documents from the Internet was

non-intrusive and not subject to the bias associated with data collected through interviews (Abbot *et al.* 2004). According to Bryman (1989), because the job descriptions are official documents, the collection process did not influence the contents of these documents. Perhaps more importantly for this study, the documents provided information that was very useful in contextualising and clarifying the semi-structured interview stage of the study (Shaw *et al.* 2002; Elston and Fulop 2002). Shaw *et al.* (2002) have argued that documentary data analysis could be useful in informing other stages of the research process. The documentary method was particularly useful in this study because it provided an opportunity to explore how public health policy filtered into job descriptions and person specifications of community learning disability nurses. In addition, because the data collection took place online it was not necessary for me to be present at the research sites (Mogalakwe 2006). The documentary method was considered for this study also because it was regarded as an effective and efficient tool in public health policy implementation analysis and as a methodology (Abbott *et al.* 2004). Another reason for adopting this method was because documentary research is useful in identifying areas that need further research (Stewart 1984). Consequently, it is usually used in conjunction with other methods such as interviews and surveys when conducting research into policy implementation (Abbott *et al.* 2004). Given the exploratory sequential multiple methods approach to this study, it was therefore appropriate to analyse job descriptions in this exploratory phase of the study. Another important reason for using the documentary method originated from the observations made by Bailey (1982) who noted that documents do not react to the researcher as participants would, and also that the data collected does not change during the collection process. Furthermore, using the documentary

method was useful because it was possible to collect a large sample (Cohen *et al.* 2007). This was important because larger sample sizes improve confidence in the data, and consequently in the results and findings obtained. Finally, this stage of the study was important in the process of my theoretical sensitisation (Glaser 1978, 1992), which was essential in stage 2 of the study.

4.1.4 Limited availability of documents, incomplete documents, errors in documents, biases, and preparation for analysis are cited in literature as weaknesses and disadvantages of documents (While 1987; Appleton and Cowley 1997). However, it was important for me to note that the first four weaknesses primarily referred to historical narrative documents. These issues were not relevant in this study. The last point regarding preparation for analysis was in the context of paper copies, and also the preparation of different types of documents in the same study. In this study all documents were electronic, and therefore they were easily transferred into the data analysis software without further processing. With regards to the types of documents used in this study, there were only two types, which largely had similar formatting. Furthermore, the research focused on specific data within these documents, and therefore the issues raised were insignificant in this current study.

## **4.2 Documents**

4.2.1 According to Guba and Lincoln (1981) a document refers to any written material that was not produced for the purpose of research. In this study documents were considered to be a useful and valuable source of high quality data (Treece and Treece 1986; Punch 2005; MacDonald and Tipton 1996;

Hammersley and Atkinson 1995). Job descriptions are compulsory guidance of how NHS employees implement health policy and therefore it was reasonable to analyse such guidance in order to understand how community learning disability nurses were expected to enact their public health roles. Abbott *et al.* (2004), and Lewis *et al.* (1999) have argued that analysing documents such as job descriptions is important in understanding policy implementation because such documents did not always follow government policy and policy guidance. In this study analysing job descriptions was useful in providing information about the extent to which these documents made references to relevant public health policies (Abbott *et al.* 2004). This was important for this study because studies have shown that documents often fail to adequately reflect policies, which they are supposed to reflect and operationalize (Lewis *et al.* 1999; Abbott *et al.* 2001). Elston and Fulop (2002) have noted that similar documents were not comparable. In this study job descriptions analysed were from across NHS community learning disability nurse bands 5 to 8, and variation in policy content in these documents was to be expected.

4.2.2 Atkinson and Coffey (1997) have observed that documents are shared in such bureaucratised organisations such as the NHS. This study took place after the implementation of *Agenda for change* (DH 1999c), and similarities of job descriptions and role specifications within each band were expected across geographical boundaries. Abbott *et al.* (2004) have noted that the sharing of such documents reduces the number of significant differences between such documents across different organisations. Analysing job descriptions was important in understanding role expectations for community learning disability

nurses. One of the questions the study sought to answer related to how public health policy was reflected in learning disability nurses' role expectations as expressed in job descriptions; therefore, a systematic analysis of job descriptions in stage 1 of the study seemed to be the most logical approach.

### **4.3 Sampling**

4.3.1 A wide range of sampling strategies exists in qualitative research that was possible for this study (Patton 1980; Janesick 1994). According to Burns (2000) non-probability sampling is used in qualitative research. The sampling strategies need to be determined by the aims and questions of a study (Punch 2005). In addition, Marshall (1996) has highlighted the need for a pragmatic, and flexible approach to sampling in qualitative investigations. Furthermore, Punch (2005) has suggested that sampling needs to be principled and based on the research design. The author also argued that '*...the sample must fit in with other components of the study...and, be consistent with the study's logic...*' (Punch 1998, p.194). One of the key aims of this study meant that there was a need to target community learning disability nurses' job descriptions and person specifications which were considered to be '*data rich*' regarding public health policy implementation for people with learning disabilities. Therefore deliberate or purposive sampling (Wilmot 2005; Glaser and Strauss 1967) seemed a logical sampling approach for this stage of the study. The reasons for adopting a purposive sampling approach were threefold. Firstly, purposive sampling allows for the sample design to be altered as data emerges (Wilmot 2005). This was very useful in targeting the collection of documents that were appropriate and relevant for the study. Secondly, this sampling approach allows concurrent data collection and

analysis. This was useful because subsequent data collection and analysis was influenced by emergent themes (Glaser 1992). This allowed for a more focused approach to data collection and analysis as the project progressed. In addition, the purposive sample was determined by theoretical saturation of the data (Morse 1995; Sandelowski 1995; Byrne 2001). Although this was useful in that the sample size was flexible, there was very little guidance in literature as to what theoretical saturation meant in practice (Morse 1995; Guest *et al.* 2006), or what the numerical figure in documentary research might be. There was also no guidance as to how a researcher could demonstrate theoretical saturation. In this study I relied on Morse (1994) who suggested that general purposive sample sizes of ( $n = 100 - 200$ ) were necessary to reach theoretical saturation. At the proposal stage it was envisaged that at least 100 documents were going to be collected, but in the end the actual sample size was ( $n = 203$ ) (see *Table 4a*). The other general guidance I relied on was from Guest *et al.* (2006). This regarded the need to demonstrate the trail of data sources that demonstrated theoretical saturation. In this thesis, this is demonstrated in chapter 7 through the use of extracts from all data sources.



Table 4a: Details of job descriptions (*n* = 203)

	England	Northern Ireland	Scotland	Wales
<b>Total number of documents</b>	171 84.2%	6 3%	16 7.9%	10 4.9%
<b>Band</b>				
5 ( <i>n</i> = 63)	62 30.5%	0	0	1 0.5%
6 ( <i>n</i> = 87)	68 33.5%	4 2%	10 4.9%	5 2.5%
7 ( <i>n</i> = 47)	37 18.2%	2 0.9%	5 2.5%	3 1.5%
7 ( <i>n</i> = 6)	4 2.0%	0	1 0.5%	1 0.5%
<b>Titles</b>				
5 ( <i>n</i> = 63)	<ul style="list-style-type: none"> <li>• Community clinical nurse</li> <li>• Community service nurse</li> <li>• Community learning disability nurse</li> <li>• Community nurse</li> <li>• Community nurse (children)</li> <li>• Community nurse (Learning disability team)</li> <li>• Community nurse for adults with learning disabilities</li> <li>• Community nurse for children with learning disabilities.</li> <li>• Community practitioner (Learning disabilities)</li> <li>• Community rehabilitation nurse</li> <li>• Community staff nurse</li> <li>• Health care support worker</li> <li>• Learning disability nurse</li> <li>• Nurse</li> </ul>			<ul style="list-style-type: none"> <li>• Community learning disability nurse</li> </ul>

	<ul style="list-style-type: none"> <li>practitioner (Community)</li> <li>• Primary care access staff nurse</li> <li>• School nurse (learning disabilities)</li> <li>• Staff nurse</li> </ul>			
6 ( <i>n</i> = 87)	<ul style="list-style-type: none"> <li>• Assessment nurse (learning disability)</li> <li>• Community learning disability nurse</li> <li>• Community mental health therapist (Learning disability)</li> <li>• Community nurse</li> <li>• Community nurse (Care manager)</li> <li>• Community nurse (Epilepsy specialist)</li> <li>• Community nurse (Health action planning)</li> <li>• Community nurse (Learning disability and bereavement)</li> <li>• Community nurse (Life limiting illness)</li> <li>• Community nurse for children with disabilities</li> <li>• Community nurse for learning disability</li> <li>• Continuing care co-ordinator</li> <li>• Continuing healthcare assessor</li> <li>• Family support nurse</li> <li>• Health facilitation co-ordinator</li> <li>• Health facilitator</li> <li>• Health needs assessor</li> </ul>	<ul style="list-style-type: none"> <li>• Community learning disability nurse</li> </ul>	<ul style="list-style-type: none"> <li>• Community learning disability nurse</li> </ul>	<ul style="list-style-type: none"> <li>• Community learning disability nurse</li> <li>• Community nurse – Care manager</li> </ul>

	<ul style="list-style-type: none"> <li>• Intensive support practitioner</li> <li>• Learning disability health facilitator</li> <li>• Learning disability hospital liaison nurse</li> <li>• Learning disability liaison nurse</li> <li>• Learning disability liaison nurse</li> <li>• Nurse specialist</li> <li>• Nurse specialist (Child &amp; Adolescent Mental Health) – Learning disabilities</li> <li>• Primary care liaison nurse</li> <li>• Senior nurse (Continuing healthcare)</li> <li>• Senior staff nurse</li> <li>• Special school nurse</li> <li>• Specialist nurse (Child &amp; Adolescent Mental Health Service)</li> </ul>			
7 (n = 47)	<ul style="list-style-type: none"> <li>• Acute liaison nurse (Therapist for vulnerable adults with learning disabilities)</li> <li>• CAMHS learning disability behaviour nurse specialist</li> <li>• Community learning disability nurse</li> <li>• Community nurse (learning disabilities)</li> <li>• Community nurse for children with disabilities</li> <li>• Complex care</li> </ul>	<ul style="list-style-type: none"> <li>• Community learning disability nurse</li> <li>• Community nurse (learning disabilities)</li> <li>• Team leader</li> </ul>	<ul style="list-style-type: none"> <li>• Community learning disability nurse</li> <li>• Liaison nurse</li> <li>• Nurse specialist</li> <li>• Project manager (Disabilities – health inequalities)</li> </ul>	<ul style="list-style-type: none"> <li>• Community learning disability nurse</li> <li>• Nurse team leader (learning disability – community)</li> </ul>

	<ul style="list-style-type: none"> <li>case manager</li> <li>•Health facilitator and acute liaison nurse</li> <li>•Health facilitator for adults with learning disabilities</li> <li>•Hospital liaison nurse specialist</li> <li>•Lead health facilitator</li> <li>•Lead nurse (community)</li> <li>•Operational manager (Community learning disability team)</li> <li>•Primary care liaison nurse (learning disabilities)</li> <li>•Specialist forensic nurse practitioner (Community LD team)</li> <li>•Team leader (community)</li> <li>•Team leader (community)</li> </ul>		
8 (n = 6)	<ul style="list-style-type: none"> <li>•Clinical nurse specialist (Children with learning disabilities)</li> <li>•Head of LD Community nursing – specialist practitioner</li> <li>•Health access manager and head of LD development team</li> <li>•Nurse consultant (learning disabilities) and health co-ordinator.</li> </ul>	<ul style="list-style-type: none"> <li>• Consultant nurse – learning disabilities</li> </ul>	<ul style="list-style-type: none"> <li>• Team manager (Community learning disability team)</li> </ul>

4.3.2 The policy and practice changes noted earlier that impacted on how community learning disability nursing is understood appear to have impacted on the job titles of community learning disability nurses. In addition, the re-organisation of health and social care provision has led to changes in the organisations, and environments in which community learning disability nurses work. This has resulted in a superabundance of confusing job titles for community learning disability nurses. Although no studies have investigated these emerging job titles for community learning disability nurses, the increasing number job titles in nursing practice have been commended upon (Warner 2011). Because of the absence of an up-to-date universal definition of a 'community learning disability nurse' discussed earlier, and the absence of universal criteria for community learning disability nursing jobs, it was important to have inclusion and exclusion criteria for this study.

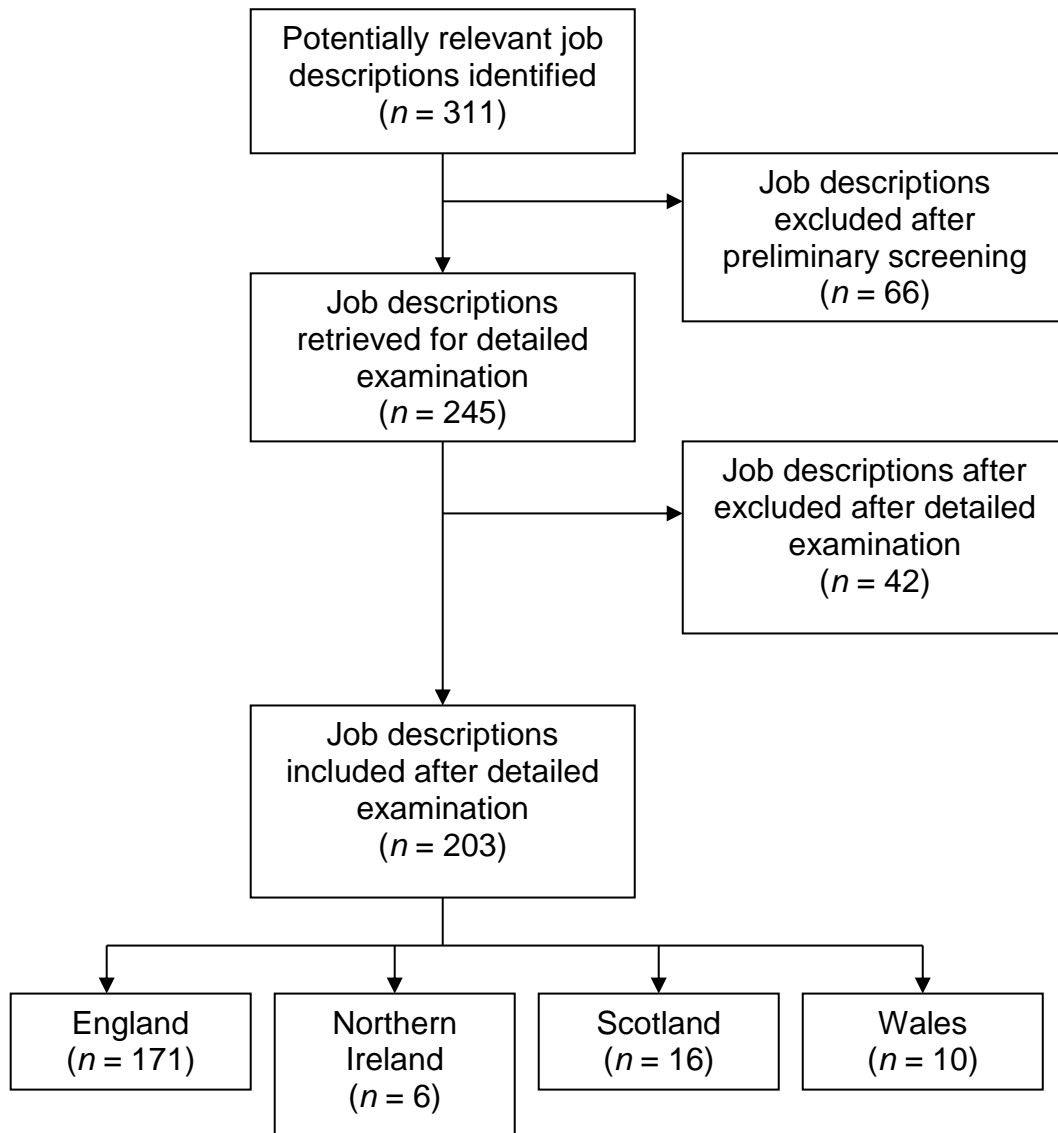
4.3.3 Firstly, job descriptions were included in this study if the pre-requisite professional qualification was learning disability nurses with RN5 or RNLD NMC registration. Job descriptions, which accepted alternative NMC registration instead of RN5 or RNLD, were excluded. The second inclusion criteria was that the post-holders were part of community based multi-disciplinary team providing health services to people with learning disabilities in a variety of settings. Job descriptions were excluded if post-holders were required to provide services in one specific location. Thirdly, job descriptions were included if they required the post-holders to carry a caseload. Job descriptions were excluded if post-holders were not required to carry a caseload. In addition, job descriptions were included if the post-holders were able to admit and discharge people with learning disabilities from their

caseload. Job descriptions were excluded where post-holders were not able to admit and discharge people with learning disabilities from their caseload. Finally, to be included job descriptions needed to be explicit that the post-holder's primary role was meeting the health needs of people with learning disabilities.

4.3.4 The practical method of data collection involved registration with the NHS recruitment website for England and Wales for automated forwarding of all relevant documents as soon as they appeared on the website. In addition to this I undertook a weekly manual electronic search of the website, NHS Scotland recruitment website, and the various websites used to advertise jobs by Northern Ireland health service organisations.

4.3.5 The process of selecting job descriptions involved preliminary screening on-line, followed by retrieval of job descriptions that needed more detailed examination. Job descriptions were then assessed if they met the inclusion or exclusion criteria. *Figure 4a* illustrates the sampling process for job descriptions.

Figure 4a: Illustration of how job descriptions were sampled.



#### 4.4 Preparing data for analysis

4.4.1 The documents collected were either in Microsoft Word or Portable Document Format. These formats were acceptable for analysis using NVivo8 (QSR 2008), and therefore there was no need for any alterations to be made to the documents before analysis. On collection, all documents were coded with a combination of prescriptive prefixes plus random abbreviations. There were four prefix codes for job descriptions, and four prefix codes for person specifications (JD5-, JD6-, JD7-, JD8-, PS5-, PS6, PS7-, PS8-); each

depicting *Agenda for change* community learning disability nurse band. Before data collection could begin, a project had to be setup using NVivo8. Within the project I created four folders, one for each category (defined by band) of documents. This approach is reflected in more detail in chapter 7 of this thesis. The second task I had to undertake was to clearly define the stages of data analysis. These stages are highlighted in the section on data analysis in this chapter, and each stage is illustrated in detail in chapter 7 of this thesis.

## **4.5 Data analysis**

4.5.1 Documentary data analysis is the systematic critical examination of documents and it is synonymous with content analysis (Holsti 1969). Neuendorf (2002) has defined content analysis as "*... an in-depth analysis using quantitative or qualitative techniques...*". Bryman (1989) has suggested that thematic content analysis is a typical and appropriate method in analysing documents. In Bryman's approach this involves a quantitative identification and analysis of themes that emerge from the documents. This was problematic for me. One weakness of thematic content analysis I noted in the literature is that it focuses on the overt content and ignores the intended and perceived meaning of documents (May 2001). A second issue I have with a purely positivist approach to content analysis is that it focuses on information that is measurable. This is because positivism treats social phenomena such as policy implementation as having objectives that are independent of the perceptions of those involved (Jupp and Norris 1993). A third problem I have with the positivist perspective of documentary analysis is that it fails to contextualise documents (May 2001). What I found useful is the work undertaken by Schofield (1997). Schofield (1997) through analysing NHS



documents identified words (word frequencies – quantitative), which were then used to form interpretative '*content categories*', which were then densified into latent meanings. Using this approach enhanced thematic content analysis through the application of interpretative techniques. I found this approach more appropriate. In other words content analysis can be both quantitative and qualitative (Ericson *et al.* 1991; May 2001). In addition, Scott (1990, p.32) suggested that;

*'It may be that a single striking word or phrase conveys a meaning out of all proportion to its frequency; and a non-quantitative approach may be better able to grasp the significance of such isolated references. The content analyst must engage in an act of qualitative synthesis when attempting to summarise the overall meaning of the text and its impact on the reader'.*

In this study I adopted the later approach to content analysis with the quantitative element only used for frequency word searches. The process I followed is discussed in detail later in this chapter. What I found most useful about this approach was the flexibility of being able to pick only the elements that were relevant for the analysis I needed to carry out. In addition, qualitative content analysis allowed the deconstruction of the documents and interpretation of intended, perceived, and content meanings in order to construct themes (Ericson *et al.* 1991). This was essential because in order to construct any meaning from the job descriptions and person specifications, the process of analysis needed to be able to extract the meanings and content intended, and perceived (Scott 1990). In this study the '*content meaning*' specifically referred to two elements within the documents. The first related to '*role descriptors*' and the second related to '*public health policy*

*references*' within the job descriptions and person specifications. '*Role descriptors*' and '*policy references*' formed the basis of how data was analysed and presented in this exploratory phase of the study (see chapter 7). The '*intended meaning*' was important in this study because this reflected the employers' expectations of how community learning disability nurses were expected to enact their public health roles. The intended meaning was further explored in stages 2 and 3 of this study. Analysing the '*perceived meanings*' of job descriptions and person specifications was essential because how community learning disability nurses perceive their public health roles is fundamental in understanding how they enact those roles. Perceived meaning was central to this study and this was further explored in stages 2 and 3.

4.5.2 While the process of extracting data from the documents itself was relatively straightforward with the use of NVivo8, presenting the interpretive results in a way that would be credible was rather challenging. Platt (1981) has provided three useful alternatives, which I considered. The first option involved defining very clearly how the systematic process of analysis was undertaken (this is discussed later in this chapter) right at the outset (Platt 1981). I was however conscious of the difficulties of demonstrating how the results are linked to each point in the analysis as noted by May (2001). Platt (1981) has also highlighted the fact that this approach is dependent on the credibility of the researcher. The second option would have involved reporting each stage of the data analysis process separately (Platt 1981). Given the large volume of data involved this was impractical. The third option involved the use of extracts to illustrate the emergent themes. As suggested by Platt (1981), in

this study I employed some aspects of each of all the three strategies in the analysis, and presentation of the findings.

4.5.3 The usefulness of computing programmes in qualitative data management has been highlighted in literature (Parahoo 2006; Wong 2008). The main advantage for using computer assisted data analysis (CAQDAS) was that I was able to analyse a very large amount of documents in a very short space of time which would not have been remotely possible by use of manual methods (Parahoo 2006). Another advantage was that it was easy to store and retrieve data as the study progressed and became more complex (Morisson and Moir 1998). It is however important to highlight that the use CAQDAS in qualitative research does not replace the research's interaction with the data, but rather that it makes data handling and processing easier and faster.

4.5.4 As said earlier, data analysis in this stage was managed using NVivo8 (QSR 2008), and its usefulness has been highlighted in literature (Wong 2008; Walsh 2003; Wiltshier 2011). There were a number of reasons for opting for NVivo8. To begin with, NVivo8 can assist with sorting, coding, and extracting data; this was important given the large amount of data involved. The coding, sorting, and extraction of data would have been impossible without these functionalities. In addition, it was possible to manage documents in different and original formats. This speeded up the process quite significantly. It was also possible to undertake word frequency searching. This capability was useful in extracting role descriptors and identifying references to public health policies. What was also particularly useful is the speed at which it was

possible to execute these searches. Furthermore, the software allowed single word, Boolean, and proximity searching. This was particularly useful because it allowed the words extracted during frequency searching to be located within the documents in which they appeared. This then aided the extraction of relevant data in their context. Additionally, after data extraction, NVivo8 allowed the arrangement of similar data into groups or categories. Importantly NVivo8 allowed the use of *a priori* categories. Finally, it was possible to create memos within NVivo8 itself, which were then linked to the data. Finally, although this functionality was eventually not used, NVivo8 has capability to manage a research project from the design stage to the reporting stage.

4.5.5 Data analysis involved seven stages of systematic searching, organisation, and coding / categorisation (Bogdan and Biklen 1982; Patton 2002; Dey 1993). While coding is highlighted in literature as core in the analysis of qualitative documentary data, no step-by-step guide could be located. In this study the 7 stages were influenced by a number of researchers. The main focus was to be able to demonstrate the linkages between the data and the findings.

4.5.5.1 **Analysis stage 1:** The first stage in the data analysis process involved the creation of *a priori* theoretical categories (Quine 1951; Wong 2008; Kant 1787). *A priori* refers to the way of establishing transcendental, and logical knowledge (Kant 1787). This is in contrast to the *a posteriori* approach, which is used to create hypothetical and empirical knowledge (Kant 1787). The *a posteriori* approach was used in stage 2 of this study. *A priori* categorisation was chosen over

emergent categorisation because the expected public health roles under consideration at this stage were known. The *a priori* categories were created from the UK Faculty of Public Health's public health role descriptors, and the *National profiles* for learning disability nurses (see *Table 7a* and *Table 7b*). The public health roles of community learning disabilities had to be understood from this context, and existing public health policy. Therefore, the use of *a priori* categories was essential (Copelston 1960). There were 5 categories (healthcare access, health education, health promotion, health promotion and health surveillance).

4.5.5.2 **Analysis stage 2:** Word frequency searching was conducted to identify public health role descriptors and public health policy references that appeared in the documents. Stemler (2001) has noted that words that appear more frequently in documents could be reflective of key themes. However, in this study it was not so much the frequency count that was of interest but the appearance of any words that described public health roles and any references to public health policies. Another point was that I was more interested in establishing how many documents contained any of the words rather than how frequently each word appeared. In other words I was interested in identifying words of interest (Stemler 2001).

4.5.5.3 **Analysis stage 3:** Following identification of words of interest (Stemler 2001) I undertook single item, Boolean and proximity searching (Wong 2008), and extracted sentences / sections in which

the words were used (see chapter 7). Extraction of data in its context was important in strengthening the validity of the findings and conclusions made in this thesis (Bowling 2009; Stemler 2001).

#### 4.5.5.4 **Analysis stage 4:** Analysis needed to extend beyond word searching.

What was of more interest was the coding and categorisation of the data (Ding *et al.* 2001). The initial codes (free nodes in NVivo8) were role descriptors and references to public health policy (see chapter 7). As described in data analysis stage 1 above, data was categorised using *a priori* theoretical categories. According to Krippendorff (1980) sampling, context, and recording units can be used in the coding of data. Context units of data were more appropriate for a number of reasons. To begin with, context units allowed limits to be set regarding the type of data that were recorded in each category. In addition, the use of context units was more appropriate because it allowed overlapping of data between categories. Furthermore, context units were flexible in that they could be single words, paragraphs, or statements (Krippendorff 1980).

#### 4.5.5.5 **Analysis stage 5:** Literature on how the codes could be inducted into

themes was disparate but fell predominantly into four broad groups. These groups were word-based, scrutiny-based, pawning, and linguistic-based approaches (D'Andrade 1991; Strauss and Corbin 1990; Glaser and Strauss 1967; Chamarz 1990; Ryan 1999; Sandelowski 1995). Jehn and Doucet (1997) have recommended a multiple technique approach in constructing themes, and this is what I

used in this study. The first three approaches were of relevance in this study. The first approach involved examination of repeatedly used role descriptors and policy references in the extracted data in the context in which they were used (D'Andrade 1991). This was used in conjunction with indigenous categories (Patton 1990), or what Strauss and Corbin (1990) referred to as '*in vivo coding*'. In this study the indigenous codes related to known role descriptors in the implementation of public health policies as well as public health policies and terminology used in the policy process. The second phase of theme identification involved pawning (Sandelowski 1995), or what Bernard (2000) referred to as ocular scanning or eyeballing. This involved more detailed reading of extracted data. This is similar to the manual cutting and sorting of data, and is considered useful in identifying initial or sub-themes (Bernard 2000). Using these approaches proved to be quite versatile, and non-labour intensive as I repeatedly moved back and forth over the data.

4.5.5.6 **Analysis stage 6:** After the initial themes were collated, a line-by-line analysis of each of the data extracts to which themes were related was undertaken (Glaser and Strauss 1967; Strauss and Corbin 1990; Charmaz 1990). The process itself was easy to master and undertake. It was also useful in identifying major themes as the initial themes were repeatedly collapsed and became denser. The process was repeated several times until what I considered to be the point of theoretical saturation (Strauss and Corbin 1990).

4.5.5.7 **Analysis stage 7:** The final stage in the data analysis process involved a closer scrutiny of the themes identified in data analysis stage 6. Both themes relating to roles and to policy were subjected to a process of densification (Thomas 2003). The process involved further scrutinization, and collapsing of the themes into more densified, and indigenous themes.

## **4.6 Validity and reliability considerations**

4.6.1 According to Bailey (1994) documents written for specific purposes have strong face and construct validities. Scott (1990) has suggested four measures that could be applied in assessing the validity and reliability of documents under consideration in this study. The first measure was that documents needed to be authentic. In this study all documents were official, and live documents, and it could be concluded that all the documents were authentic (Scott 1990). The second criterion is that documents used for the purposes of research need to be credible with respect to accuracy, legitimacy, and sincerity (Scott 1990). In this study all documents were collected from the NHS job vacancy websites. This approach ensured that all documents collected were legitimate, current, and credible for the purpose of the study. The third measure relates to the representativeness of the sample (Scott 1990). In this study there were two important aspects to this measure. Firstly, all documents were collected post-*Agenda for change* implementation. *Agenda for change* was aimed at ensuring standardisation of job descriptions and person specifications (see chapter 2), and therefore it was reasonable to assume that documents collected for each band reflected role expectations for community learning disability nurses across the NHS. Secondly,



documents were collected over a 12-month period in order to ensure as many documents as possible were collected. The fourth criterion for assessing reliability and validity related to intended, and interpreted meanings (Scott 1990) of documents under consideration. The purpose of job descriptions is covered in detail in chapter 2 and therefore no further detailed discussion is necessary here.

## **4.7 Conclusion**

4.7.1 In this chapter I have explored the processes of data sampling, data preparation, data analysis, validity, and reliability considerations in my approach to the documentary analysis method I used in the exploratory phase of the study. In the next chapter I explain and rationalise my choice for the grounded theory approach I used in stage 2 of the study.

## **Chapter 5: Stage 2 – Semi-structured Interviews (descriptive phase)**

### **Introduction**

This chapter commences with an exploration of the grounded theory method used in this study. This is followed by a detailed outline of the approach to sampling, and an explanation of how participants were recruited. The description of how interviews were conducted is then given followed by an outline of how interview transcripts were transcribed into text. An outline of the grounded theory data analysis method is then given. The chapter concludes by exploring the validity and reliability considerations necessary when using the grounded theory method.

The focus at this stage was on obtaining interview data from learning disability nurse consultants and other senior nurses who were involved in public health policy implementation for people with learning disabilities. This was in order to generate a one directional hypothesis that would then be tested in stage 3 of the study. These interviews partly focused on issues raised in stage 1 of the study, which was to;

1. explore how public health policies are translated into community learning disability nurses' roles in the practice setting;
2. investigate how community learning disability nurses understand and enact their public health roles in the practice setting, and
3. identify moderators of how community learning disability nurses enact their public health roles.

## 5.1 Grounded theory

5.1.1 Grounded theory (Glaser and Strauss 1967) appealed to me because it was developed for both quantitative (Glaser 1964) and qualitative research (Glaser and Strauss 1965), and could be used inductively or deductively, or both in one study. In addition, grounded theory is '*...the most widely employed interpretive strategy in the social sciences today*' (Denzin and Lincoln 1994, p.204). One of the goals of grounded theory, which was important for this study, is its use in generating theories or hypotheses from the data (Glaser 1978). Grounded theory is used to discover a basic social process conveyed in psychosocial symbols (Chenitz and Swanson 1986). Another good reason for my choice of grounded theory is that it is useful in areas where little research has been done (Wuest 2007), because it allows constant comparative analysis of the data in order to generate hypotheses and formulate theory (Glaser and Strauss 1967; Strauss and Corbin 1990).

5.1.2 The value of grounded theory in nursing research has been highlighted in existing literature (Stern and Covan 2001; Munhall 2001). More recently it has been used successfully in community learning disability nursing research (Llewellyn 2005). Another reason for choosing grounded theory was because of its usefulness in studying human behaviour in its social context (Glaser and Strauss 1967; Glaser 1978). Furthermore, grounded theory was useful because no hypothesis was required at the beginning of the study (Glaser and Strauss 1967; Glaser 1978; Charmaz 1990). Another reason for using grounded theory was that it allowed for the continuous verification of concepts (Strauss and Corbin 1998; Munhall 2001) and conceptualisation of data (Punch 2005) as the research evolved (Holloway and Wheeler 1996). In

addition to the potential for theory generation, grounded theory offered opportunities to modify and develop existing role theories (Charmaz 2006). Grounded theory is also useful in that it allows formal and substantive theories to be developed (Morse and Johnson 1991; Morse 2001). A further reason for choosing grounded theory was that it offered opportunities to modify the focus of the research as data emerged. In addition, it provided flexibility in the sample size and recruitment of participants through the use of theoretical saturation (Glaser and Strauss 1967). Grounded theory was also useful at this stage because it provided an '*insider*' view to data collection and data analysis (Stern 1994). This was particularly useful because it allowed me to contextualise the participants' experiences. Another reason for opting for grounded theory is the non-prescriptive approach to the analysis of data (Glaser and Strauss 1967; Glaser 1992).

- 5.1.3 During the conduct of this study it was important to be conscious of six key characteristics of grounded theory. The first was the need for the research to be theoretically sensitive (Glaser and Strauss 1967; Glaser 1978; Strauss and Corbin 1998). As a developing researcher I found that theoretical sensitivity was important in building my ability to theorise, and conceptualise data (Glaser 1978). In this study, the *a priori* literature review I undertook was particularly useful in my theoretical sensitisation (Carpenter 1999; Glaser 1978, 1992). It is important however to note the contentious discourse that has occurred over the years regarding the role of literature review in grounded theory studies (Wuest 2007). In addition to the preliminary literature review, undertaking analysis of job descriptions in stage 1 of this study also significantly contributed to my theoretical sensitisation. The second key

characteristic of grounded theory relevant to this study was purposive or theoretical sampling (Glaser 1978; Charmaz 1990; Strauss and Corbin 1998; Patton 1990). This is addressed in the section on sampling later in this chapter. The third relevant key characteristic of grounded theory is constant comparative analysis (Glaser and Strauss 1967). This is further explained later in this chapter. The fourth important key characteristic of grounded theory is coding and data categorisation (Glaser and Strauss 1967; Strauss and Corbin 1998). This is further discussed in the data analysis section in this chapter. Another key characteristic that was relevant in this study is memoing, and diagraming (Strauss and Corbin 1998). This is further explored in the section on data analysis later in this chapter. The sixth key characteristic of grounded theory I found particularly useful in this study was theory integration (Glaser 1978). This is discussed further in the section on data analysis later in this chapter.

- 5.1.4 On examining existing literature on the development of grounded theory I realised the development of a Straussian and Glaserian grounded theory divide over the years. I found this most unhelpful given that the alteration both Strauss and Glaser made to their approaches (Strauss and Corbin 1990, 1998; Glaser 1978, 2004) would have been expected, given the relative newness of the methodology. Although my own approach was significantly influenced by the original work (Glaser and Strauss 1967), I also found that the changes made by the authors, such as views on theoretical sensitivity (Glaser 1978; Strauss and Corbin 1998) enhanced grounded theory. Like many other grounded theorists I can foresee adopting some of the later changes to ground theory as I become a more experienced researcher.

5.1.5 In *The discovery of grounded theory* (Glaser and Strauss 1967), the authors did not assign grounded theory to a philosophical position. In *Qualitative analysis for social scientists* Anselm Strauss indicated that the development of grounded theory was influenced by pragmatism (Strauss 1987). Barney Glaser, in *Basics of grounded theory analysis* (Glaser 1992) suggested that symbolic interactionism underlie the assumptions of grounded theory. As I mentioned in chapter 3, I undertook this study from a pragmatic position. Positioning grounded theory within pragmatism appeals to me. Firstly, this is because it emphasises that practical realities need to take precedence over theoretical knowledge (Seigfried 1998). In addition, pragmatist grounded theory emphasises that knowledge can only be obtained through the generation of *a posteriori* theory obtained through induction and empirical verification. Furthermore, what was perhaps more important for me in undertaking this study is that I was more interested in generating knowledge that is relevant (Wuest 2007) to the participants and the wider body of learning disability nursing practice.

5.1.6 Although I found grounded theory to be a useful and pragmatic research method, I needed to be aware of its limitations in order to take preventative actions to avoid negative impacts on the outcomes of this study. Thomas and James (2006) have summarised the limitations of grounded theory that were relevant in this study. Firstly, because of its focus on participant experience, the knowledge generated could be difficult to generalise to the rest of the population under study. I addressed this potential limitation through my approach to reporting of the findings. In addition, although grounded theory is useful in the generation of theory and hypotheses, it would be difficult for

these to be tested if the participants are heterogeneous. I addressed this through my approach to sampling and participant recruitment. Another disadvantage is that data collection and analysis took place over a prolonged period due to the concurrent data collection, data analysis approach, and the constant comparative analysis, which meant repeatedly moving forth and backwards. Finally, because of the interaction with the participants and the data, I needed to be reflexive to minimise bias.

## **5.2 Sampling and participant recruitment**

5.2.1 An exploration of the literature revealed that non-probability sampling was widely used in qualitative studies (Burns 2000) and that a wide range of strategies exist (Miles and Huberman 1994; Patton 1980; Janesick 1994). Punch (2005) has suggested that sampling strategies need to be determined by the aims and questions of a study, and that '*...the sample must fit in with other components of the study...and, be consistent with the study's logic...*' (p.194). Generally, in grounded theory studies purposive and theoretical sampling approaches are used (Glaser 1978; Wuest 2007). In this study purposive and theoretical sampling were used because they allowed for the sample size to be altered as data emerged (Wilmot 2005). This meant that subsequent data collection was influenced by emergent themes (Glaser 1992). Because data collection in grounded theory research is driven by emergent data it was difficult to specify the sample size at the beginning of the study (Wuest 2007). Initially I targeted that ( $n = 6-10$ ) learning disability nurse consultants would be recruited through the *UK learning disability nurse consultants network*. From my own experience and discussions I had with my subject supervisor and significant other professionals in learning disability

nursing practice, and based on initial data analysis I envisaged that data would also be collected from other senior practitioners at Strategic Health Authority, and Department of Health (or equivalent) levels. Suggestions for sample sizes necessary to achieve theoretical saturation in grounded theory studies range from ( $n = 10$  to  $n = 50$ ) (Wuest 2007; Morse 1994). In this study because of the use of focused questions and the overall population size, theoretical saturation was achieved with ( $n = 17$ ) participants (see *Table 5a* and *Table 5b*).

5.2.2 In this pragmatic grounded theory stage of the study, purposive sampling (Glaser and Strauss 1967; Patton 1990; Wilmot 2005) was used to recruit the participants (McCann and Clark 2003). The decision to involve nurse consultant at this stage of the study was based on the need for 'key informants' with a wide view of public health policy implementation for people with learning disabilities (Parahoo 2006). The nurse consultants who participated in this study had supervisory responsibilities for community learning disability nurses. In addition, the key criteria for inclusion of 'other' participants was that they needed to be Nursing and Midwifery Council registrants with significant involvement with public health policy implementation for people with learning disabilities. The first 'other' participant was the English Department of Health mental health and learning disability lead. Although this participant was not an NMC registrant as a learning disability nurse, their involvement as a 'key informant' in this study was important because they were the only person in England in a position to provide an overview of public health policy implementation for people with learning disabilities across country. The participant's role included



professional leadership for learning disability nursing at the English Department of Health. Learning disability nurse consultants were not in a position to provide this important strategic overview. It is important to acknowledge that the participant's inclusion may result possible limitations for generalisation of the study findings. The focus of the study at this stage was on identifying moderators of public health role enactment by community learning disability nurses at all levels of the policy implementation process. The involvement of this participant as a key informant was important in providing useful data relating to moderators of public health role enactment of community learning disability nurses in England. The second 'other' participant from BCC in England was included because they were the only known learning disability nurse, with a senior public health role for the implementation of public health policies for people with learning disabilities in a local authority in the UK. The involvement of this participant in this study was important in providing qualitative data useful in our understanding of the importance of appropriate strategic leadership in the implementation of public health policies for people with learning disabilities. The inclusion of a participant who was not a nurse consultant in Northern Ireland was important because at the time of the study there were no relevant nurse consultants. In addition, the participant's immediate previous role was that of learning disability nurse consultant in Northern Ireland. During the contact of this study, the participant's role at the DHSSPSNI was similar to that of the English Department of Health lead discussed above (refer to rationale discussed above). Without this participant's involvement as a 'key informant', it would not have been possible to obtain data on the moderators of public health role enactment of community learning disability nurses in Northern Ireland. The

inclusion of one senior nurse from NHS London was because of their significant involvement with public health policy implementation for people with learning disabilities across the 32 London local authorities. In addition, the participant provided leadership for learning disability nurse consultants in London regarding health policy implementation for people with learning disabilities. Their involvement as a 'key informant' was therefore important in obtaining qualitative data regarding public health policy implementation, public health priorities, and moderators of public health role enactment by community learning disability nurses in London. This purposeful, focused, and limiting approach to participant recruitment was quite useful in collecting focused data. Focused data in turn was useful in the achievement of theoretical saturation (Wuest 2007).

5.2.3 There were about 28 consultant learning disability nurses in the UK at the time of this research. Initially an e-mail including information about the study and consent (Wuest 2007) was sent to all consultant learning disability nurses. Follow-up contact was then made via e-mail or telephone, targeting the initial batch of participants. Face-to-face or telephone interviews were then scheduled, allowing time in-between interviews for data transcription and analysis. Data was coded, categorised, and organised into four foundational coding families (cause, context, process, and consequence) (Glaser 1978).

*Table 5a: Descriptive phase participants (n = 17).*

<b>Country</b>	<b>Number of participants</b>	<b>Learning disability nurse consultant</b>	<b>Other (Consultant equivalent or higher)</b>	
<b>England</b>	11	8	3	Department of Health LD Lead x 1 NHS London LD Lead x 1 BCC Public health department LD Lead x 1
<b>Northern Ireland</b>	1	0	1	DHSSPSNI LD Lead x 1
<b>Scotland</b>	4	4	0	
<b>Wales</b>	1	1	0	

5.2.4 Theoretical saturation (Charmaz 2000; Strauss and Corbin 1998) was used to ensure that robust data was obtained. Sampling and interviewing continued until sufficient conceptual density was obtained for each category (McCann and Clark 2003), and mapping of links between categories could be demonstrated and diagrammed (Strauss and Corbin 1998). Having clearly defined and narrowly restricted questions at the beginning, and a narrow and clearly identified target population (Morse 1995) was very useful in achieving theoretical saturation. This approach was useful in ensuring that the categories and sub-categories that emerged in each of the foundational coding families was much more focussed and pertinent, but at the same time being open-ended and flexible to allow for theory generation (Smith and Biley 1997). What I found really useful was that although recurrence of data was important in achieving conceptual density and theoretical saturation, the quality of the data was even more important (McCann and Clark 2003).

**Table 5b:** Stage 2 participants biographical data ( $n = 17$ )

	England	Northern Ireland	Scotland	Wales
<b>Total number of participants</b>	11 64.7%	1 5.9%	4 23.5%	1 5.9%
<b>Male</b>	7 41.2%	1 5.9%	2 11.8%	1 5.9%
<b>Female</b>	4 23.5%	0	2 11.8%	0
<b>Age</b>	Not collected	Not collected	Not collected	Not collected
<b>Nursing and Midwifery Council Registration</b>				
<i>RNLD</i>	10 58.8%	1 5.9%	4 23.5%	1 5.9%
<i>Other</i>	1 5.9%	0	0	0
<i>Learning disability nurse consultant</i>	8 47.1%	0	4 23.5%	1 5.9%
<i>Other (see Table 5a)</i>	3 17.6%	1 5.9%	0	0
<b>Highest academic qualification</b>				
<i>Certificate</i>	0	0	0	0
<i>Diploma</i>	0	0	0	0
<i>Advanced diploma</i>	0	0	0	0
<i>Graduate</i>	4 23.5%	0	0	0
<i>Post graduate</i>	7 41.2%	1 5.9%	4 23.5%	1 5.9%
<b>Time in post (years)</b>				
<i>&lt; 1</i>	0	0	0	0
<i>1 – 4</i>	6 35.3%	1 5.9%	2 11.8%	1 5.9%
<i>&gt; 5</i>	5 29.4%	0	2 11.8%	0

### 5.3 Data collection

5.3.1 Holstein and Gubrium (2004) have noted that interviews are the most widely used data collection methods in interpretative qualitative studies such as this stage of this study. It has also been noted that semi-structured interviews are some of the most appropriate approaches in interpretative and perception studies (Barriball 2006). Miller and Glassner (2004) further noted that interviews are a rigorous method in exploring research participants' subjective world. In grounded theory studies semi-structured interviews are used (Glaser and Strauss 1967); Wuest 2007). This was of particular importance in this study. This is because semi-structured interviews allowed for flexibility, opportunities to ask follow-up questions, and I did not have to ask the questions in the same order (May 2001).

5.3.2 Swanson (1987), and Hutchison and Wilson (1994, 2001) have provided useful guidance on how semi-structured interviews are conducted in grounded theory studies. I developed an interview protocol with 6 questions (see *Appendix 5a*), and interviews were either contacted face-to-face or by telephone. Although I preferred face-to-face interviews, but because the participants were from across the UK, telephone interviews were used where it was difficult or not convenient for a face-to-face interview. All interviews were digitally recorded with a digital audio recorder (face-to-face) or using *Powergramo skype recorder* (voice-over-internet protocol computer software) (PowerGramo 2010). I opted for digital recording for a number of reasons. Firstly, I wanted to focus on capturing participants' responses without interruptions (Wuest 2007) inherent in note taking in order to ask follow-up questions immediately at the end of each response. In addition, I felt that I did

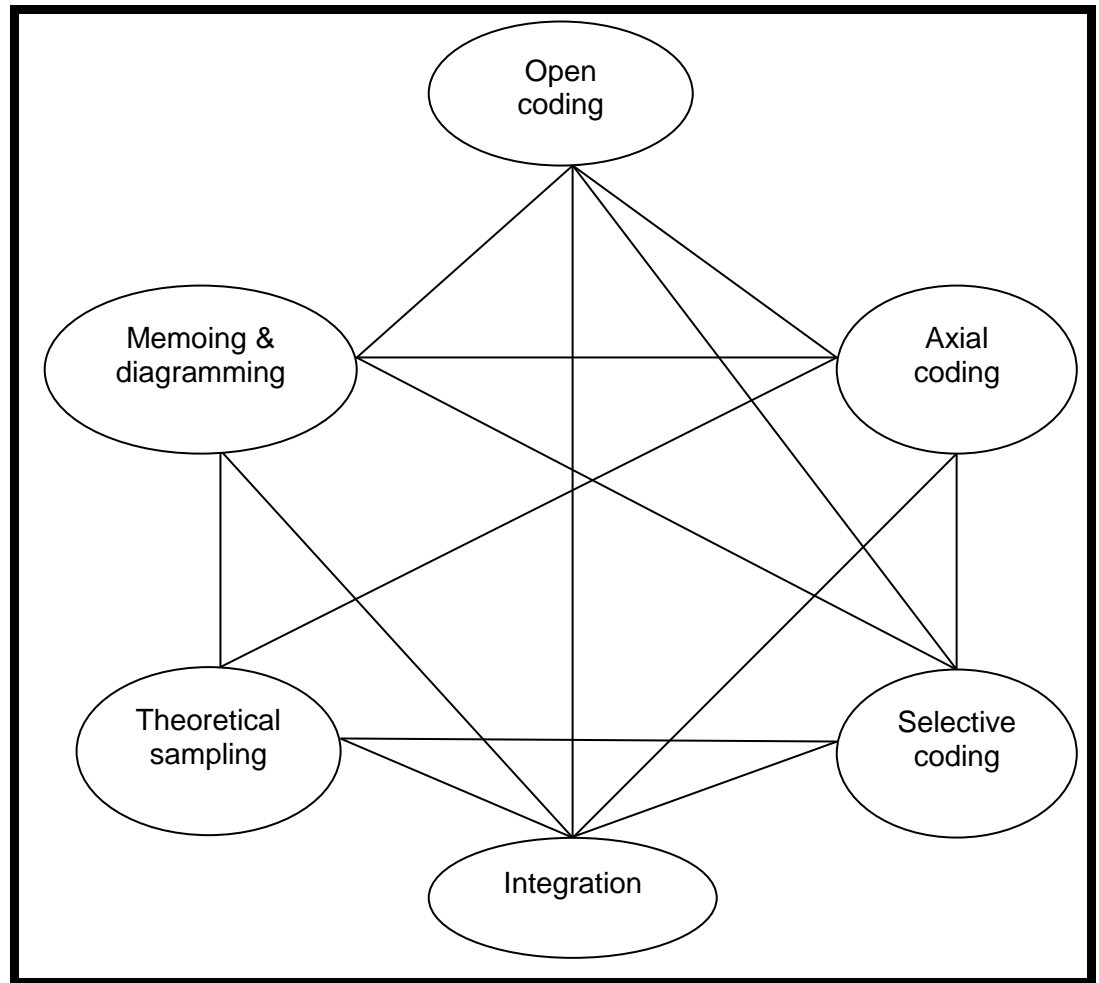
not have the training or the ethnographic experience to write accurate contemporaneous notes as suggested by Glaser (2004). Furthermore, digital recording allowed for easy transfer of data records between computer formats. This was valuable for easy storage, retrieval, and transcription. Finally, digital audio files were easier to manipulate with *Expert Scribe* data transcription computer software. This computer software facilitates easier, accurate, and rapid transcription of data into text files. After transcription, data was imported into NVivo9 (QSR 2009), and then read, coded, categorised, and assigned to a foundational coding family (see chapter 8). Although data collection and data analysis are presented separately in this chapter, it is important to point out that this occurred concurrently. As data collection, and analysis progressed over time the focus of the interviews became increasingly spontaneous. This flexibility inherent in pragmatic grounded theory allowed me to focus on refining and confirming emergent concepts, hypotheses, and relationships as the study progressed towards achieving theoretical saturation.

## **5.4 Data analysis**

### **5.4.1 Grounded theory data analysis;**

*‘...is a process of inductively deriving codes, developing hunches about properties and relationships, checking out those hunches deductively in old and new data by theoretical sampling, and developing yet another inductive theoretical hunch’ (Wuest 2007, p.253).*

*Figure 5a: Illustration of constant comparative analysis activities (Glaser and Strauss 1967).*



What is clear from the literature is that grounded theory data analysis is non-linear but organised. In practice it was quite disorderly and quite messy (see *Figure 5a*). Here I have attempted to describe what I did in a way that appears to be orderly than it was in reality. This is however clearly unfair and minimises the complexity, and webbed nature of the whole process (see *Figure 5a*).

5.4.2 At the core of grounded theory analysis is the constant comparative analysis approach, which involves examining, analysing, and interpreting data

iteratively (Glaser and Strauss 1967). Constant comparative analysis is the cornerstone of the grounded theory research method (Glaser 1978; Glaser and Strauss 1967; Patton 1990). In this study the inductive component of grounded theory was useful in identifying variables and themes from the data, while deduction was useful in the generation of hypotheses that emerged and evolved from the concepts that were identified during the analysis process. Data were constantly compared in an effort to identify, and refine categories and themes (Denzin and Lincoln 1994; Glaser and Strauss 1967).

5.4.3 The purpose of **open coding** was to identify patterns in the data, which would then develop into concepts, and eventually begin the development of theory (Charmaz 2000) (see *Table 8a*). Open coding involved reading the data, seeking to identify and conceptually label (Strauss and Corbin 1998) role descriptors and policy references, line-by-line '*in context*' coding (Corbin 1987; Strauss and Corbin 1998) (see *Appendix 8a*), and '*clustering*' (see *Appendix 8b*) as categories began to emerge. '*In vivo*' and sociological construct codes were used (Strauss 1987). '*In vivo*' codes were related to the language of policy implementation, public health, and role (Strauss 1987). Sociological constructs were based on my experiential knowledge and knowledge gained through theoretical sensitisation discussed earlier. The use of sociological constructs was useful in the conceptualisation of the data (Strauss 1987). As data collection continued, open coding began to be undertaken concurrently with other aspects of the data analysis process, including theoretical sampling of the data (Wuest 2007) as I moved backwards and forth and engaged with the data.



5.4.4 **Axial or theoretical coding** (Strauss and Corbin 1990, 1998) involved a *posteriori* categorisation, sub-categorisation, further clustering, and linking of the data using more abstraction (Strauss and Corbin 1998) through inductive, and deductive reasoning (see *Table 8b*). In reality theoretical coding began during the open coding process and was aided by using NVivo9 (QSR 2009). In order to see how the categories fitted together I used four foundational coding families (cause, context, process, consequence) (Glaser 1978) (see *Table 8c*). I selected these four coding families because they appeared to be more relevant in theoretically explaining what was taking place. I systematically considered each piece of data through each of the four coding families, and labelled the data as I went along. In reality memoing and diagramming was also prominent during this process.

5.4.5 The purpose of **selective coding** was two-fold (see *Figures 8h and 8i*). Firstly, during this process I collapsed the theoretical codes into selective codes and then further collapsed the selective codes into themes. Secondly, the focus was on building links between categories in order to identify the core category (Strauss 1987; Charmaz 1990; Strauss and Corbin 1998). The process itself involved constant comparative analysis of data, incorporating a cyclical and webbed process of oscillating between all the elements of the analysis process (see *Figure 5a*). Memoing, diagramming, and theoretical coding were significant activities during this stage of the analysis process. To arrive at the core category, I had to engage in more abstract thinking (Strauss and Corbin 1998) and collapsed all the categories into two, which were further collapsed in one all encompassing core category. Strauss (1987) has provided a useful 6-point guide (high frequency, explains majority of variations

in data, allows optimum analysis variation, links well to all *a posteriori* theoretical categories, has consequences for existing theory, evident in the data), which was essential in assessing and identifying the core category.

5.4.6 Like other processes of data analysis, ***theoretical integration*** (see *Figure 8e*) (Glaser 1978) took place concurrently with other analyses. The main other activity at this data analysis stage being memoing. The process itself involved primarily three core activities. The first involved focused and more detailed selective sampling of the *a posteriori* theoretical categories (Glaser 1978). The second activity involved selective sampling of themes from stage 1 of the study and existing pertinent literature that could contribute to further categorisation and conceptualisation (Glaser 1978). The third activity involved collating, clustering, and linking all the *a posteriori* categories and *a posteriori* subcategories (Glaser 1978). I then clustered all the categories into two broad categories from which the core category eventually emerged.

5.4.7 ***Diagramming*** (Glaser 1978) did not occur at any one particular point in the data analysis process but occurred concurrently with other analyses, and evolved over time (see *Figures 8a, 8b, 8c, and 8d*). Core diagramming involved mapping foundational coding families, and the links and relationships identified during theoretical integration.

5.4.8 The process of ***memoing*** (Glaser and Strauss 1967) involved reflective and reflexive thinking, and writing on how the emerging categories and subcategories linked together, and explained the emerging hypothesis on community learning disability nurses' involvement with public health policy

(see *Figures 8k and 8l*. Memoing was a systematic and continuous process that looked at how data could be conceptualised into all possible hypotheses (Glaser 1978).

5.4.9 As can be realised from the discussion above, the complexity of the process of grounded theory data analysis cannot be underestimated. Consequently, reporting and discussion of the results is also complex. I thought it might be prudent to give a brief overview of how I reported the results in chapter 8 at this point. How the results are reported is important in how the discussion, and synthesis are presented (May 1987). During the process of presenting the results I was also aware that analysis and synthesis needed to be conceptual and theoretical, rather than descriptive (Glaser 1978). The discussion section in this thesis integrates all the three stages. This point will be evident in chapters 10, 11 and 12. An important element of how results were reported demonstrates how data analysis was undertaken (see *Figure 5a* in this chapter). In chapter 8 I report the results using;

1. selected extracts showing the data for each of the categories;
2. figures presenting outcomes for each of the analysis undertaken;
3. a diagram for each of the four foundational coding families; and,
4. a diagram demonstrating links between the categories and core category.

## **5.5 Validity and reliability of grounded theory analysis**

5.5.1 The flexibility of grounded theory has resulted in its evolution in different directions (Peshkin 1993; Whitemore *et al.* 2001; Chiovitti and Piran 2003). Consequently, how validity and reliability can be demonstrated in grounded

theory studies is complex, and could be considered as ambiguous (Lomborg and Kirkevold 2003) because it has tended to reflect post-positivist validity and reliability tests. The most commonly used guidelines I noted, and of relevance to this current study were related to authenticity and trustworthiness (Lincoln and Guba 1985). In demonstrating rigor in this study I used three standards of trustworthiness / credibility (Lincoln and Guba 1985), auditability / authenticity (Guba and Lincoln 1981), and fittingness / applicability / transferability (Glaser 1978).

5.5.2 The concept of 'auditability' is important in grounded theory in order to underpin any emergent theory. This study has attempted to demonstrate how findings may validate how community learning disability nurses may enact their public health roles in meeting the health needs of people with learning disabilities. By providing an audit trail I have attempted to provide theoretical justification for the conclusions arrived at from the data. In addition, continuous reference to existing literature throughout the data analysis process was important in ensuring validity, reliability and rigour of the findings. It is however important to acknowledge that the process of qualitative data analysis is not an exact science, and therefore the findings need to be interpreted in the context of the researcher's reflection and interpretation of the data. Despite a clear audit trail being provided in this study, it is important to highlight that another researcher using may very well come down to alternative conclusions. For this reason, it is not possible to directly make comparisons between the findings in this study and other studies.

5.5.3 I had to demonstrate that the work undertaken is rigorous, credible and trustworthy (Lincoln and Guba 1985; Denzin and Lincoln 1994; Carpenter 1995). By using the generic foundational coding families of cause, context, process, and consequence (Glaser 1978), *a posteriori* categorisation, and conceptualisation, it could be reasonably argued that the findings are consistent. There is also a reasonable degree of confidence in the relevance and applicability of the findings to other contexts in learning disability nursing practice (Denzin and Lincoln 1994). In chapter 8 I have attempted to demonstrate the credibility of the findings by using extracts from original data (Strauss and Corbin 1990) and used memoing to articulate my own views about public health role enactment by community learning disability nurses (Locke *et al.* 1993). In addition, I have demonstrated and illustrated the data that supports and represents the conclusions made about how community learning disability nurses enact their public health roles (Denzin and Lincoln 1994). Furthermore, I have published (see *Appendices 1b-1e*), and will continue to publish and share the findings of this research with the participants and professionals in learning disability nursing practice. Sharing these findings will provide an additional source of evaluating the research (Kirk and Miller 1986).

5.5.4 Another approach in ensuring rigor involved following guidelines that improved the meaning and applicability of the findings to other community learning disability nurses in corresponding situations (Guba and Lincoln 1981; Carpenter 1995). As with trustworthiness, the use of generic foundational coding families of cause, context, process, and consequence (Glaser 1978) in hypothesis generation was important. It could be reasonably argued that the

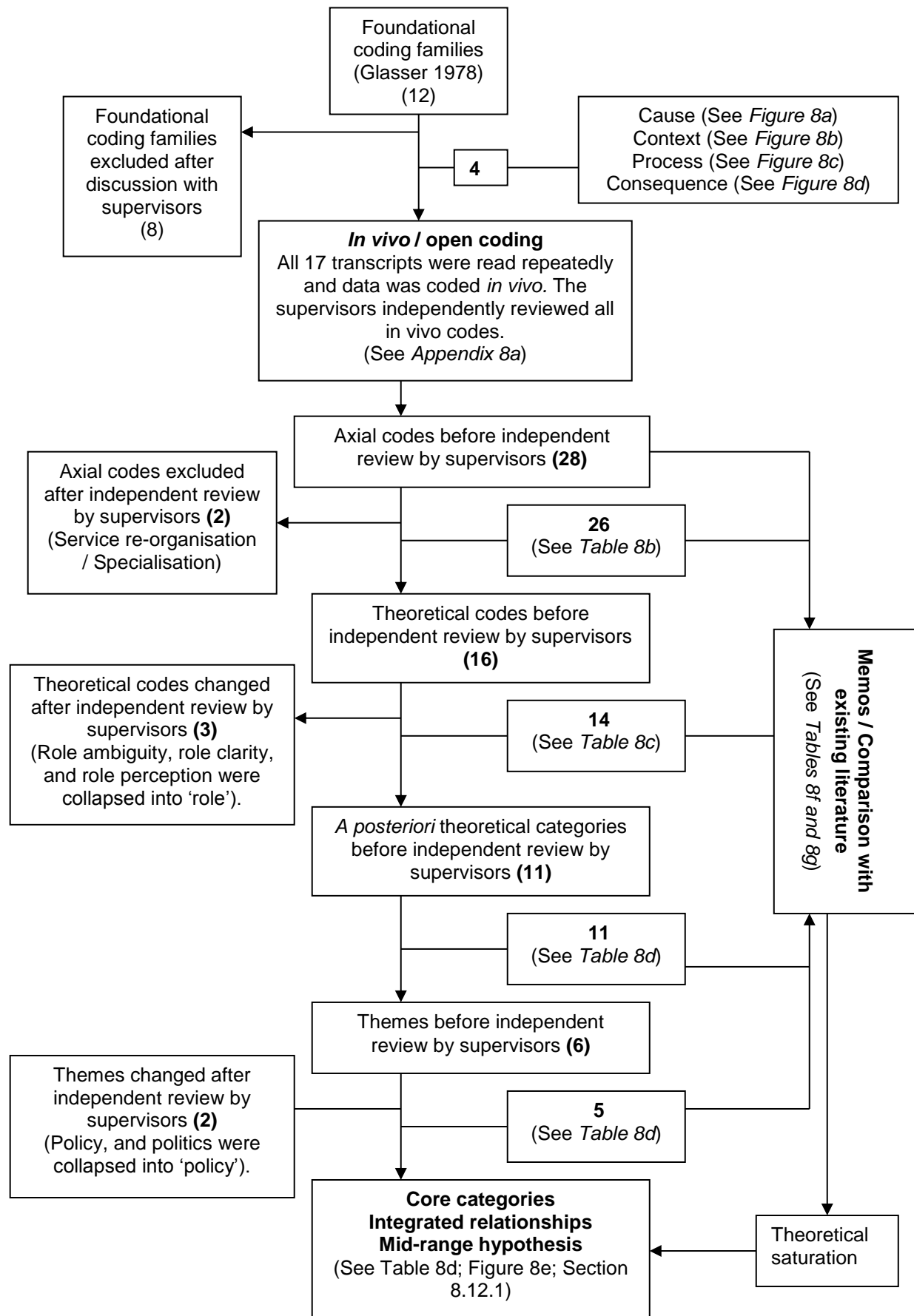
findings have a reasonable degree of confidence in their relevance, and applicability to other contexts in learning disability nursing practice (Denzin and Lincoln 1994). The use of the context coding families is likely to be useful in allowing the consumers of this research to assess the fittingness of the findings of this study to similar situations. To demonstrate transferability further, I have used literature to link every stage of this study, the findings, and *a posteriori* categories to existing concepts (Chiovitti and Piran 2003). I have also followed the guidance offered by Glaser (1978) regarding the need to constantly compare the data and the emergent hypothesis in order to accomplish fittingness.

5.5.5 The final approach I used to demonstrate rigor was to ensure that the methods I used, and the conclusions I have reached are clearly traceable and auditable (Guba and Lincoln 1981). In addition, during data analysis and interpretation I had my processes, foundational codes, axial codes, theoretical codes, *a posteriori* categories, themes, core categories, integrated relationships and emergent hypothesis independently reviewed by my supervisors. The process of independent review of the findings was complex and systematic (See *Figure 5b*). This process was an integral part of the whole data analysis process so that data coding could be identified and addressed at every stage. However, despite this systematic and rigorous approach, it is important to acknowledge that there could be many differing interpretations of the findings from this study.

5.5.6 My initial plan was to use the 12 foundational coding families (Glaser 1978). This was challenged by one of my supervisors who suggested that these were

too many, and that I needed to focus on those coding families that were more relevant to the research questions. Each transcript was read repeatedly, and data coded *in vivo* (See *Appendix 8a*). Each piece of data was then assigned to a foundational coding family and diagrammed (See *Figures 8a-8d*). My supervisors independently reviewed both the *in vivo* codes and assigned foundational coding families. No changes were suggested. My initial titles of axial codes which seemed appropriate to me was challenged on a number of occasions by one of my supervisors who suggested that the titles needed to be more abstract. At the end of this data analysis stage I generated 28 axial codes. Following independent review by my supervisors, 2 codes were excluded because they were a repetition of other codes. Initially I generated 16 theoretical codes, which were reduced to 14 following independent review. No changes were suggested to the *a posteriori* categories following independent review. Six themes were generated before independent review by one of my supervisors. Following the independent the independent review, two themes were combined into one. The core categories (See *Table 8d*), integrated relationships (See *Figure 8e*), and hypothesis (See *Section 8.12.1*) were also independently reviewed by my supervisors. Following this review, it was suggested that my hypothesis suggested a causal relationship between variables. This was subsequently modified (See *Section 8.12.1*).

Figure 5b: Process of independent review of findings (stage 2).





5.5.7 There are two possible types of hypothesis that could be generated through the use of grounded theory in this study, and that is grand, or substantive (Strauss and Corbin 1990). The former could only be generated if the research was undertaken in a variety of contexts. It was possible to generate the latter from studying public health role enactment in the specific situation and context of community learning disability nursing practice (Strauss and Corbin 1990). In stage 2 of this study the aim was to generate a hypothesis based on consistent and dependable data. In order for me to demonstrate data consistency or dependability (Denzin and Lincoln 1994) I have demonstrated in this chapter how I approached the constant comparative analysis method. In chapter 8 I have demonstrated through the use of extracts and diagramming, how patterns of data emerged and linked together (Glaser 1978). The nature of grounded theory method precludes generalizability. To some researchers this is a limitation of the method.

5.5.8 In this chapter I have explained, detailed, and rationalised the sampling (Strauss and Corbin, 1990), interview, and data analysis methods used, and how data was handled during each stage of the analysis process (Glaser 1978; Strauss 1987). In chapter 8 I have illustrated how data was processed and presented at each stage of the analysis.

## **5.6 Conclusion**

5.6.1 In stage 2 of this study I intended to generate a one directional hypothesis that could be tested in stage 3. Grounded theory was therefore an appropriate consideration because it allowed me to go beyond role description and generate a substantive hypothesis. It is important however to highlight that

conducting grounded theory research was a real challenge which required very high levels of systematic critical thinking and abstraction in order to generate a meaningful substantive hypothesis. As we will see in chapter 8, data generated at this stage supported a substantive one directional hypothesis. This was important because the statistical evidence that would emerge from testing this theory would significantly enhance our understanding of the relationships that exist between the public health role moderators of community learning disability nurses.

5.6.2 In the following chapter I explain and justify my choice of the survey method I used in stage 3 of the study to test the relationships between the moderators of public health role enactment by community learning disability nurses, which were identified in this stage of the study.

## Chapter 6: Stage 3 – Questionnaire Survey (explanatory phase)

### Introduction

Stage 3 completes this 3-stage exploratory sequential multiple method study. In stage 2 of this study I focused on describing moderators of how community learning disability nurses enacted their public health roles. In addition, I focused on developing a substantive one directional hypothesis (Creswell 2009). It is appropriate at this point to state the one directional hypothesis that emerged from stage 2 of this study. This is important in order to contextualise the discussion in this chapter;

***‘Public health role enactment by community learning disability nurses is influenced by individual factors, professional factors and organisational factors.’***

Following data analysis from stage 2 of this study, a survey questionnaire was developed in order to gather data from a wider group of community learning disability nurses who had involvement with the implementation of public health policies for people with learning disabilities. The focus of the study at this stage was on;

1. explaining the moderators of public health role enactment by community learning disability nurses in order to validate a hypothesis that these influences extended beyond current propositions of role theory; and,
2. testing this hypothesis in order to explain some of the key relationships that existed between some of the moderators of public health role enactment by community learning disability nurses.

## 6.1 The survey method

6.1.1 Survey is a data collection method within the positivist epistemology (Breachin and Sidell 2000), and is useful where variable control is not necessary or appropriate (Bryman and Cramer 1997). The term '*survey*' can be used to describe a research method, a method or a tool (Creswell 2009). In the context of this study the term is used in all three contexts as appropriate. According to Isaac and Michael (1997) the term has a wide range of uses including being able to describe and explain what exists. In addition, surveys can be used in describing or explaining a phenomenon (Punch 2003; Robson 2002; Kelly *et al.* 2003). Fink (2002) has further explained that a survey is useful in collecting valuable information in order to describe or explain knowledge. According to Denscombe (1998), surveys provide a view of a population from a sample. Kelly *et al.* (2003) have noted that the survey method has its origins in applied social research and is widely used in health, and healthcare studies (Hayes 2000). As noted in chapters 4 and 5, there are always methodological options in undertaking research. My view is like that of many others and, that is, the choice of method needs to be driven by the question that needs to be answered (Punch 2003). Surveys can be used to collect research information on participants' knowledge, behaviours, and attitudes on related or unrelated phenomena (Connelly 2009). In this study the focus was on community learning disability nurses' knowledge, behaviours, and attitudes regarding public health role enactment (Gomm 2000). Literature examined suggests that in designing the survey I had to follow a standard format. Creswell (2009) has provided useful checklists for both the survey design and for the survey questionnaire design, which I used.

6.1.2 There were a number of advantages of survey research, which appealed to me in this study. A survey was attractive at this stage of the study because it offered an opportunity to test the relationships of the moderators of public health role enactment by community learning disability nurses with a large group of participants than what would have been possible by use of interviews. Another advantage was that it was possible for me to reach a large number of participants very quickly (Hayes 2000; Kelly *et al.* 2003), economically (Hayes 2000; Kelly *et al.* 2003; Bowling 1997), and easily (Hayes 2000). In addition, through the survey I was able to collect quantitative data (Creswell 2009) that was useful for me to test the relationships, and the strength of the relationships between the moderators of public health role enactment by community learning disability nurses.

6.1.3 Like most other approaches to generating knowledge, the survey method has its disadvantages, which I had to be aware of. Firstly, it was important for me to be aware of the lack of detail and contextualisation of the data that I obtained through the survey method. This is particularly important in this study, which dealt with experience (Kelly *et al.* 2003). Secondly, I also needed to be conscious of the poor response rates associated with survey research (Connelly 2009). This was particularly important, and eventually influenced the approach I took to sampling and participant recruitment I adopted.

6.1.4 According to Fink (2002), data collection in a survey can be undertaken using a number of approaches including observations, interviews, or self-administered questionnaires. In this study I used online self-administered

questionnaires (Sue and Ritter 2007). My rationale for the online self-administered questionnaire is discussed later in this chapter.

## **6.2 Survey questionnaire development**

6.2.1 There is a rich body of evidence of the use of self-administered survey questionnaires as data collection tools (Openheim 1992; McKenna *et al.* 2006). Denscombe (2003), and Bowling (2009) have extensively discussed the advantages of collecting survey data using self-administered questionnaires. For me there were a number of advantages, which were of particular significance. Firstly, other than my time there was no other direct cost involved. Furthermore, no further training was required for me to be able to administer the questionnaires. In addition, because data collection was done online, it was possible for me to reach participants in every corner of the UK relatively easily at no direct cost. Finally, and perhaps more importantly, because data collection was done online, responses were electronic. As a result data was much easier to handle, process, and store.

6.2.2 Despite all the advantages highlighted here I needed to be aware of the cautions provided by Bowling (2009) regarding some of the drawbacks of self-administered questionnaires. Of particular importance is the potential low response rate as a result of the minimal contact between the participants and myself. As said earlier, this was addressed during the sampling and participant recruitment process.

6.2.3 Creswell (2009) suggested that an existing survey instrument whose validity and reliability would have been tested could be used. However in this area of research no existing instrument could be found. As a result I had to develop and pilot test the survey instrument for the study (Punch 2003). In addition to the guidance provided by Creswell (2009) on how to develop an effective survey questionnaire, Czaja and Blair (2005), Fink (2003b), and Robson (2002) have also provided guidance I found useful. According to Czaja and Blair (2005), the first consideration I had to make was regarding the broad areas of information I needed to collect in order to answer the question of the research at this stage. Czaja and Blair (2005) provided a useful model, which was useful in ensuring that the survey questions linked with the overall questions of the research. The four broad areas identified and in which specific questions needed to be asked were; participants' employer, participants' job descriptions, participants' public health roles, and participants' perceptions of their perceptions of employer's priorities regarding public health policy implementation for people with learning disabilities (see *Appendix 6b*). After deciding on the categories in which I needed to ask questions, the next step involved writing the survey items. The questionnaire was developed as a rating scale (Streiner and Norman 2008; DeVellis 2003). In this, Creswell (2009), and Czaja and Blair (2005) have provided useful step-by-step guides. Of particular importance was the warning by Czaja and Blair (2005) that open-ended questions were notoriously difficult and time-consuming to process. As a result I opted for predominantly *Likert scale*-type questions (Czaja and Blair 2005). After developing the items, I developed written instructions (Czaja and Blair 2005). This process involved several drafts before arriving at the pilot test version (Czaja and Blair 2005). Before

pilot testing the questionnaire I had my subject supervisor, community learning disability nurses, and senior nurse academics to expertly review it in order to ensure validity (Connelly 2009; Coughlan *et al.* 2009).

6.2.4 After designing the questionnaire I had to decide on the best method of administration. An on-line method was particularly appealing. Fricker and Schonlau (2002), and Sills and Song (2002) reported that the Internet provided a new platform for administering survey questions since the 1990s. According to Creswell (2009), SurveyMonkey (2010) has proved to be a useful platform where researchers can develop their own online surveys. What I found particularly appealing regarding SurveyMonkey was its ability to automatically generate graphed descriptive statistics. The second, and perhaps the most important was its ability to download the data into an excel spread sheet. This was particularly useful because it eliminated the need for data transcription. This made the process of importing the raw data into SPSS19 for analysis much easier. In addition, I found the potential protection against data loss (Ilieva *et al.* 2002) quite appealing. Another advantage of using an online questionnaire was that it was possible for me to make the items interactive. Furthermore, it was possible to build in error checking to ensure that the questionnaires were completed correctly. In addition, it was also possible to control how questionnaires were completed (Solomon 2001), by guiding the participants through the questionnaire. This prevented participants from skipping questions. A further advantage was that there were significant printing and postage cost savings (Cobanoglu *et al.* 2001). Mertler (2002) has observed that online data collection is convenient and efficient. In addition, Andrews *et al.* (2003) have noted that the distribution of



questionnaires could be undertaken very quickly. Finally, another appeal of SurveyMonkey for me was the potential for better response rates in online surveys reported by Ilieva *et al.* (2002). However, I needed to be aware of the contradictory evidence regarding response rates that was provided by Fricker and Sconlau (2002).

6.2.5 The most commonly cited potential limitation of online survey I had to take account of was poor response rates (Schaefer and Dillman 1998; Witmer *et al.* 1999; Fricker and Scanlou 2002). This was of particular importance in this study because of the potential impact on the reliability of the findings in the event of poor response rates. In order to minimise the likelihood of poor response rates Carbonaro and Bainbridge (2000) have provided a very useful checklist. I had to ensure that the questionnaire was easily accessible, easy to complete, and required basic computing skills for completion (Carbonaro and Bainbridge 2000). Another limitation of the online survey method I needed to take account of was highlighted by Lefever *et al.* (2007), and this related to sampling. They advised that researchers need to take into account the impossible task of achieving a random sample. This significantly influenced my approach to sampling and participant recruitment as discussed later in this chapter.

6.2.6 Following feedback from my subject supervisor and others, I needed to pilot test the questionnaire. Kelly *et al.* (2003), and Oppenheim (1992) have provided a detailed rationale for pilot testing a questionnaire. Dillman (2000) has suggested a step-by-step 4-stage process on pilot testing a questionnaire. In addition, Bowling (2009) has provided a useful guide that

was useful in deciding my approach to pilot testing the questionnaire. The first approach involved setting up a pilot test questionnaire on Survey Monkey, and recruiting a purposive sample of participants. There were principally three reasons for this. Firstly, I needed feedback on the clarity of the items in the questionnaire. In addition, I needed to test the Internet links and the interactivity of the questionnaire to ensure that there were no errors in the design. Furthermore, I needed to assess the time it took to complete the questionnaire so that this was included in the information pack. My second approach to pilot testing the questionnaire involved further face-to-face and telephone discussions with potential participants for two principal reasons. The first reason I have already mentioned earlier, and this related to enhancing the validity of the questionnaire (Bowling 2009). The second reason for this approach was to ensure that the items were not prone to a wide range of interpretations (Mallinson 1998). Following the pilot study, data was analysed, and my supervisors independently reviewed findings. Minor amendments were made to the questionnaire.

### **6.3 Sampling and participant recruitment**

6.3.1 Punch (2003) has suggested that the approach to sampling need to be logical and consistent with overall research design, and the research question. Another main point in my approach to sampling was the need to ensure that the sample provided opportunities for maximum observations of the independent variables (Punch 2003). Furthermore, I needed to ensure that all bands of community learning disability nurses were adequately represented in the sample. As can be seen in *Table 6a* below, the total population under consideration was relatively small, and thinly distributed across the whole of

the UK. In addition, bands 5 and 8 constituted very small numbers. Punch (2003) has suggested that where the focus of the study was on understanding relationships between variables, sampling needed to be deliberate rather than random. Punch (2003, p.38) further suggested that in attempting to decide on my approach to sampling, I needed to ask myself only one of these two questions:

1. *'How important is variability, especially variability in the independent variable(s)?', or*
2. *'How important is representativeness?'*

*Table 6a: UK registered learning disability nurses.*

	England	Northern Ireland	Scotland	Wales	TOTAL
<b>NMC register</b>	14 934	658	1 812	945	<b>17 961</b>
<b>Community nurses</b>	2 786	0*	289	333	<b>3408**</b>
<b>% of total on NMC register</b>	15.51%	0*	1.61%	1.85%	<b>18.97%**</b>
<b>Data source</b>	NMC register as at 03/08/2011				
	NHS Information centre (2011)	Statswales online (2010)	SWISS as at 13/10/2010	DHSSPS (2010)	
<b>Sources:</b> <ol style="list-style-type: none"> <li>1. Statswales online.</li> <li>2. Project Support Analysis Branch (2010) NI Health and Social Care. Workforce Census. Belfast: DHSSPS.</li> <li>3. ISD Scotland National Statistics (2010). NHS Scotland Workforce Statistics. SWISS as at 13/10/10.</li> <li>4. NHS Information Centre (2011). Non-medical workforce census (Online) (Accessed 01/08/11).</li> </ol> <p>* Community nurses not clearly identified in the data. ** Excludes Northern Ireland data.</p>					

Only one of these questions needed to be answered in undertaking the survey. The choice of which question was answered needed to depend on the research question I was asking (Punch 2003). As discussed earlier regarding the focus of the research at this stage, it was more important to achieve representativeness than variability. The choice of sampling as a result needed to be purposive. At this point I was quite aware of the criticisms of bias associated with purposive sampling and the limitations on generalizability of the findings (Rosenthal and Ronsow 1975; Creswell 2009). However, Punch (2003) has suggested that any survey could contribute new knowledge as long as the researchers pay attention to detail in the conduct of the research and the reporting of the findings.

6.3.1 In probability sampling every community learning disability nurse would have had an equal chance of being selected to participate in the study (Raj 1972; Cochran 1963). It would have been impossible to obtain a representative sample if I had used probability instead of non-probability sampling (Salant and Dillman 1994). An examination of the literature revealed that there are six approaches to purposive sampling (modal instance sampling, expert sampling, quota sampling, non-proportional quota sampling, heterogeneity sampling, and snowball sampling) (Raj 1972; Watters and Biernacki 1989; Pitard 1993; Punch 2003; Parahoo 2006; Yancey *et al.* 2006; Morrow *et al.* 2007; Bowling 2009).

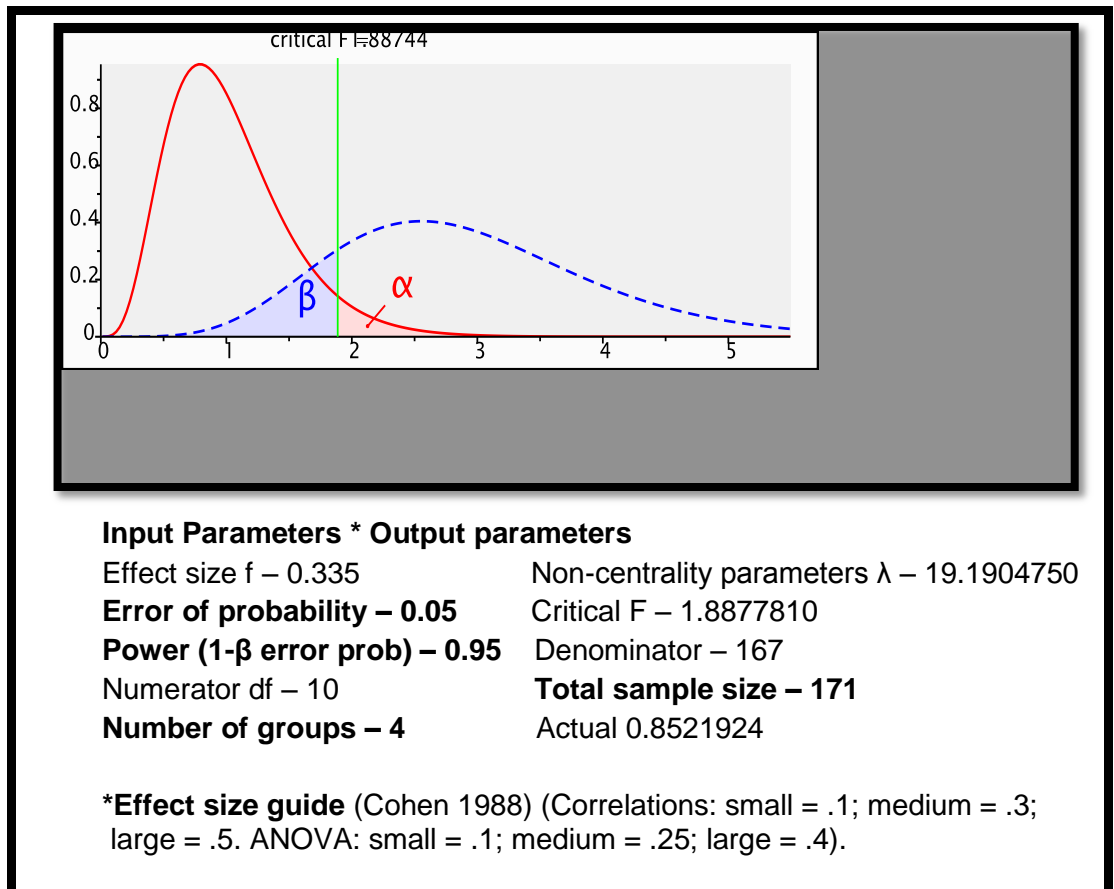
6.3.2 Using the same approach that the sampling method needed to have logic and a theoretical drive, the most appropriate options were quota sampling, and non-proportional quota sampling. Apart from the data from Scotland (see

*Table 6a*) all other data was not categorised into bands. Consequently it was impossible to use the quota sampling method. As said earlier, the most important factor was representativeness rather than variability (Punch 2003). Therefore non-proportional quota sampling was the most appropriate sampling method. Non-proportional quota sampling is the non-probability equivalent of stratified random sampling. In keeping with the questions, which I needed to answer, non-proportional quota sampling was also appropriate because it was flexible enough to allow me to recruit sufficient numbers for a reasonable discussion for each of the four bands of community learning disability nurses under consideration. In addition, this allowed me to target each subgroup separately. Furthermore, this approach was appropriate because I intended to compare the results of the subgroups in terms of their public health roles. I also expected variations between the subgroups because of the different role expectations of different bands of community learning disability nurses, which were evident in the job descriptions, and person specifications analysed in stage 1 of this study. Without using non-proportional quota sampling it would have been impossible to have adequate representation (Morrow *et al.* 2007) from bands 5 and 8 subgroups, and from each of the four countries of the United Kingdom.

6.3.3 After deciding on the sampling strategy, the next step was to calculate the size of the sample. In addition to the guidance from Fink (2003b), and Punch (2003) I consulted a statistician on sample size calculation. Following advice from the statistician, and given the approach to sampling, I used the G\*Power sample size calculator (Heinrich State University 2011). The input parameters used for the calculation were influenced by the key proposed tests and was

based on Cohen (1988) (see *Figure 6a*) and the appropriate sample size suggested was ( $n = 171$ ) (see *Table 6b*). Dividing the sample into the four subgroups was more challenging due to the non-existence of any published guidelines on how this could be done for non-experimental / non-randomised

*Figure 6a: Explanatory phase sample size calculation (G\*Power)*



studies. I adhered to the ‘*representativeness*’ standard (Punch 2003), focusing on the low incidence levels expected for bands 5 and 8 nurses. Suggestions for the smallest ‘*representative*’ sample which could give reliable statistics, ranged from ( $n = 10$ ) upwards (Morse 1994). Using the sample of ( $n = 17$ ) achieved in stage 2 of this study as a baseline I targeted this as the minimum for band 5 and 8 nurses (see *Table 9a* for distribution of participants).

Table 6b: Stage 3 participants biographical data (n = 171)

	England	Northern Ireland	Scotland	Wales
<b>Total number of participants</b>	120 70.2%	8 4.7%	24 14%	19 11.1%
<b>Male</b>	33 19.3%	3 1.8%	13 7.6%	10 5.8%
<b>Female</b>	87 50.9%	5 2.9%	11 6.4%	9 5.3%
<b>Age</b>				
30<	24 14%	0	4 2.3%	3 1.8%
31-49	55 32.2%	6 3.5%	15 8.8%	13 7.6%
>50	41 24%	2 1.2%	5 2.9%	3 1.8%
<b>Nursing and Midwifery Council Registration</b>				
<i>RNLD</i>	120 70.2%	8 4.7%	24 14%	19 11.1%
<i>Other registration (RMN / RGN / Child Health / Specialist practitioner)</i>	34 19.9%	3 1.8%	12 7%	7 4.1%
<b>Band</b>				
5 (n = 19)	15 8.8%	0	0	4 2.3%
6 (n = 67)	32 18.7%	7 4.1%	17 9.9%	11 6.4%
7 (n = 59)	49 28.7%	1 0.6%	6 3.5%	3 1.8%
8 (n = 26)	24 14%	0	1 0.6%	1 0.6%
<b>Highest academic qualification</b>				
<i>Certificate</i>	9 5.3%	1 0.6%	1 0.6%	0
<i>Diploma</i>	32 18.7%	1 0.6%	10 5.8%	5 2.9%
<i>Advanced diploma</i>	30 17.5%	3 1.8%	4 2.3%	5 2.9%
<i>Graduate</i>	29 17%	2 1.2%	5 2.9%	7 4.1%
<i>Post graduate</i>	20 11.7%	1 0.6%	4 2.3%	2 1.2%
<b>Length of community nursing experience (years)</b>				
< 1	10 5.8%	0	0	2 1.2%
1 – 4	41 24%	3 1.8%	9 5.3%	6 3.5%
> 5	69 40.4%	5 2.9%	15 8.8%	11 6.4%

## **6.4 Data collection**

6.4.1 The rationale for using SurveyMonkey was discussed earlier in this chapter. The section covering the pilot testing also gives details of some of the processes involved in administering the questionnaire. What was important at this stage was to ensure collection of good quality data. To ensure the quality of the data, a general checklist provided by Punch (2003) which includes the need to maintain professionalism and researcher control during collection was very useful.

6.4.2 Participants were recruited through various local and national networks for learning disability nurses (see *Appendix 6a*). Four Internet sites containing a copy of the survey questionnaire (see *Appendix 6b*) were created on SurveyMonkey, one for each band. An e-mail containing information about the study, consent, confidentiality, and a link to each of the four sites was sent to all potential participants (see *Appendix 6c*). During the period of data collection, I checked the website several times a day to ensure that it was functioning correctly, and also to monitor the progress of the responses. The decision to stop data collection was based on the achievement of minimum targets for the subgroups, and the overall sample size.

## **6.5 Data analysis**

6.5.1 As said earlier, the main focus at this stage of the study was on analysing the relationships between moderators of public health role enactment by community learning disability nurses. Therefore correlational analysis seemed to be the most appropriate, and logical



primary approach to data analysis (Punch 2003, 2005). The most important type of analyses needed to be those, which helped me to answer the research question. The process of data analysis involved the use of SurveyMonkey and SPSS19.

6.5.2 In literature there are predominantly two types of statistics, descriptive and inferential. Rosenberg (1968) has provided a useful framework, which further informed my approach to data analysis. Punch (2003, p.45) has provided a 3-step guide to statistical analysis of survey data;

1. *'...summarising and reducing data...,*
2. *...descriptive level analysis ..., and,*
3. *...relationship analysis...'*

6.5.3 The first stage of the data analysis process involved automatic calculation of response rates using SurveyMonkey. This was particularly useful for item 7 of the questionnaire (see chapter 9). This was useful in providing a visual representation of the public health roles each band of community learning disability nurses were involved in (see *Figures 9h-9k*).

6.5.4 The second stage involved exporting data from SurveyMonkey into SPSS19 using the codes given in *Table 6c*. At this stage the main focus was on describing variables (mean, standard deviation, frequency distribution, range) (Pallant 2007; Hinton *et al.* 2004; Miller

*et al.* 2002). Calculating **statistical mean scores** was important because they demonstrated data clusters. Used together with histograms and bar graphs was useful in providing graphical and visual representations of the data. Calculating **standard deviations** was useful in measuring the spread of moderators of public health role enactment. Obtaining **frequencies** was useful because I was able to demonstrate the distribution of the scores in each of the sub-samples. The **ranges** were useful in that they provided indications of the statistical dispersions of the scores.

*Table 6c: Data codes for explanatory phase analysis*

Item**			
Q1 – Role clarity in JD			
Q2 – Role review			
Q3 – Daily activities		1	Strongly agree
Q4 – Role perception		2	Agree
Q5 – Role value (importance)		3	Not sure
Q6 – (Not included in the scale)		4	Disagree
Q7 – Perceptions of employer’s priorities		5	Strongly disagree
Q8 - Perceptions of employer’s knowledge			
Band		Employer	
5	1	NHS	1
6	2	Local Authority	2
7	3	Both	3
8	4		

\*\* For detailed information see the questionnaire (*Appendix 6b*).

6.5.5 The third stage of data analysis involved analysing and establishing **variable relationships** (Pearson correlations) (Pallant 2007; Hinton *et al.* 2004; Miller *et al.* 2002). As said earlier in this chapter, correlation analysis was the primary focus for data analysis in this stage of the

study in order to test the moderators of public health role enactment by community learning disability nurses. This was useful in describing the strength of the relationships between the variables. Although it was possible to calculate the direction of correlations, but because of the possibility that other variables were likely to influence the variables under consideration, directional correlation analysis was not considered to be important. Pearson correlation coefficient ( $r$ ) is the most common bivariate correlation statistic (Pallant 2007; Hinton *et al.* 2004; Miller *et al.* 2002), and I adopted it for this study. For interpreting the relationships different authors suggest different interpretations. Cohen (1988) has provided guidelines, which are widely used. These were adopted for this study (see *Table 6d*). In interpreting the results, significance indicates how much confidence we should have in the results in order to accept or reject a hypothesis. In this study, if the value in the Sig. (2-tailed) column was equal or less than 0.05, I concluded that there was a significant difference in the mean scores in the dependent variable for each of the groups (Pallant 2007).

*Table 6d: Pearson correlations interpretation guide (Cohen 1988)*

Small	$r = .10$ to $.29$
Medium	$r = .30$ to $.49$
Large	$r = .50$ to $1.0$

6.5.6 The fourth, and final stage in data analysis involved analysing data for **reliability** (Cronbach's alpha), and for **ANOVA** (Levene and Tukey HSD) (Pallant 2007; Hinton *et al.* 2004; Miller *et al.* 2002). The main

items of the survey questionnaire as a scale were Q1-Q5 and Q7-Q8. Given that the survey instrument was new, one of the key elements of data analysis process was to test its reliability (Pallant 2007). Assessing the reliability of the questionnaire as a scale was important because it allowed me to measure its internal consistency, or simply show how the items '*hang together*' (Pallant 2007, p.95). The commonly used measure of internal consistency I used was the Cronbach alpha coefficient (Pallant 2007). According to DeVellis (2003), for a scale to be reliable a Cronbach alpha coefficient value of .7 or above is the most ideal. However Pallant (2007) pointed out that Cronbach alpha coefficient values of .5 were widely accepted where items in the rating scale were less than 10. The process involved testing the items overall, and then repeating the test whilst excluding 1 item at a time.

6.5.7 The purpose of undertaking the ANOVA test was to see if there were any differences between bands, and between employer groups (Pallant 2007) on how they influenced how community learning disability nurses enacted their public health roles. ANOVA was useful because it allowed me to break the data according to the band, and the employer (Hinton *et al.* 2004). My interest was on the differences between the groups so I undertook One-way ANOVA between groups analysis (Miller *et al.* 2002). One-way ANOVA was useful for a number of reasons. Firstly, in addition to the Pearson correlations, what I was able to do with ANOVA was to look at the way bands, and employer groups differed internally (Pallant 2007). In addition, I was able to

calculate within group variation and between group variation (Pallant 2007). This was important because a significantly greater between group variation than within group variation was going to be indicative of statistically significant differences between bands, and between the employer groups (Pallant 2007). Furthermore, calculating ANOVA using SPSS19 was useful in that at the end of the test, the software would report whether the F ratio was significant or not (Miller *et al.* 2002). ANOVA compares the variance (variability in scores) between the different groups (believed to be due to the independent variable) with the variability within each of the groups (believed to be due to chance). The F ratio represents the variance between the groups, and a large F ratio indicates that there is more variability between the groups caused by the independent variable. A significant F ratio indicates that we should reject the null hypothesis but it doesn't tell which groups differ.

6.5.8 Following the ANOVA test, I needed to undertake a post-hoc test in order to analyse how employer groups differed from each other, and how bands differed from each other (Pallant 2007). In SPSS19 a number of post-hoc multiple comparisons can be undertaken including Bonferroni, Scheffe, Gabriel, Duncan, and Tukey HSD (Miller *et al.* 2002). According to Pallant (2007) Tukey's honestly significant different (HSD) test, and the Scheffe test are the most commonly used post-hoc tests. The Scheffe test is recommended where the sensitivity of the Type 1 error is of significance. The drawback with Scheffe for me was that its sensitivity would have made it difficult for me to observe the

group differences (Pallant 2007). I therefore opted for the Tukey HSD test, which provided a better opportunity for me to detect the differences between the bands, and between employer groups (Pallant 2007; Fowler et al. 2002). Examination of the multiple comparisons table showed exactly where the differences among the groups occurred. SPSS19 asterisked the scores in the mean difference column. This meant that the two groups being compared were significantly different from one another at the  $p < .05$  level (Pallant 2007).

## **6.6 Validity and reliability considerations**

6.6.1 The reliability of a survey instrument is of importance in research. Literature examined suggested that there are predominantly two broad types of reliability; internal consistency reliability, and temporal reliability (DeVellis 2003; Punch 2003). Internal consistency reliability is important in assessing the reliability of a scale (DeVellis 2003). This was of little importance in this study because the primary focus for developing the questionnaire was not as a scale measure. My focus was on establishing temporal reliability in order to ensure that participant responses were stable (Punch 2003). The main reason for this approach was that I wanted the questions in the survey questionnaire to be answered easily and consistently (DeVellis 2003). My main approach in establishing temporal reliability was the test-retest method I described in the pilot section of this chapter.

6.6.2 My approach to validity was driven by the need to ensure that the data collected with the questionnaire would represent the underlying influences (DeVellis 2003; Punch 2003) on public health role enactment by community learning disability nurses. In addition, I also wanted to ensure that the participants were able to answer the questions as I intended. Literature provided a wide range of different types of validity that could be assessed. In this study I was more interested in content validity and construct validity (DeVellis 2003). Content validity was important because I needed to ensure that the survey questionnaire items were adequate in sampling relevant data. In order to assess content validity I had the questionnaire items reviewed by experienced researchers in the field. In addition, I also asked for feedback from participants during the pilot-testing phase. I was interested in the construct validity of the questionnaire because I needed to ensure it measured correlates (DeVellis 2003) of public health role enactment by community learning disability nurses. Analysing pilot data, and the main survey data contributed towards assessing the construct validity of the survey questionnaire (DeVellis 2003).

## **6.7 Conclusion**

6.7.1 In the explanatory stage of the study I intended to explain the correlates of the moderators of public health role enactment by community learning disability nurses. The survey method was therefore an appropriate approach, because it allowed me to explain the moderators of public health role enactment by community learning

disability nurses. By using the survey method, although this was secondary, I was also able to further assess the validity and reliability of the survey questionnaire instrument. As we will see in chapter 9, data generated at this stage supported the substantive one directional hypothesis generated in stage 2 of this study.

6.7.2 In the following section of this thesis, beginning in chapter 7, I report on the findings from each of the 3 stages of the study.



## **SECTION 3: RESULTS**

### **Introduction**

The ultimate goal of this study was to generate new knowledge relating to how community learning disability nurses enact their public health roles in the context of role theory. It is important to point out that this knowledge needed to be communicated to a wider audience in learning disability practice. In addition to communicating the outcomes of this research to the wider audience, the research needed to meet standards for a doctoral research study. It is therefore important that how the findings and interpretations are presented in this thesis, and published in journals, enable the consumers to learn from it in order to improve public health policy implementation for people with learning disabilities, while at the same time being able to meet the other goals noted above.

This study was a 3-stage exploratory sequential multiple methods study. As noted earlier, each of the stages was relatively independent in its own right. Additionally, each of the stages sits within a different methodology. It is therefore only prudent and appropriate that each of the 3 sets of results is reported separately. This section therefore contains 3 chapters.

Chapter 7 reports the findings and conclusions from stage 1 of the study. Chapter 8 reports the findings and conclusions from stage 2. Chapter 9 reports on the findings and conclusions from stage 3 of the study. An important element of research is to demonstrate how findings are arrived at and how conclusions are made. Therefore how each of the results chapter is

structured reflects the theoretical drive and methods used in each of the stages.

## Chapter 7: Results 1 – Documentary Analysis

### Introduction

Here I present the findings, and my conclusions from the exploratory documentary stage of the study (stage 1). Perhaps it would be useful for me to explain my rationale for my approach to how the findings and conclusions are reported here. Constas (1992), and Chenail (1995) provided me with a useful starting point. This research had a QUAL→quant notation (Morse 2003). While there were some quantitative elements in the results in stage 1 of the study, the results were predominantly narrative. As a result I took a view that reporting needed to demonstrate in a systematic approach how and where the themes and conclusions emerged. In order to achieve this, my reporting therefore focuses on providing an audit trail, and that includes, providing the origins of the themes, and conclusions. An important element in facilitating this openness (Chenail 1995) is to ensure as much *in vivo* reporting of data as possible. By adopting this approach to reporting, the primary focus here is ensuring that the data itself is presented in its original format as much as possible in order to preserve its richness, depth, and breadth (Chenail 1995) for the readers. This is also important in order to ensure that data was provided in its original context rather than in slices, which would not help the readers to have an understanding of the findings, and conclusions. However, it is also important to acknowledge that data reduction took place at various stages in the analysis process. Where this took place details of how these decisions were made are detailed in chapter 4 of this thesis.

Chenail (1995) suggested 9 strategies which could be used to organise the presentation of data in studies of this nature, and these are; natural, no particular order, order of complexity beginning with the simplest to the complex, order of discovery (from first to last), quantitative statistics led, **theory driven, logical sequence of narratives or themes**, order of importance, and dramatic presentation. In this stage I adopted a theory driven, and methodology guided approach, complimented by the organisation of codes in order of perceived importance. Theory, and methodology driven approaches to reporting are common practice in qualitative research in health (Chenail 1995). This approach is quite important, not only on how the results are reported, but also on how the analysis and discussion takes place.

In total, the data analysis process went through 7 stages before conclusions could be made. These stages are clearly outlined throughout this chapter, and therefore no further details are given here. In order to set the context in which the data analysis took place it is important to refer to the *National profiles* of community learning disability nurses in relation to their public health roles (DH 2006c). Factor 7 (DH 2006c) clearly outlines expectations for each band in relation to public policy implementation for people with learning disabilities (see *Table 7a*).

*Table 7a: National profiles of community learning disability nurses' public health roles.*

<b>NHS Band</b>	<b>Relevant job information / Role expectation</b>
<b>5</b>	Follows policies in own role, may be required to comment. (Professionally responsible for adherence to clinical policies and procedures).
<b>6</b>	Implement policies and propose changes to practices, procedures for own area. (Implements, comments and proposes changes for policies for own area).
<b>7</b>	Propose policy or service changes, impact beyond own area. (Participates in working groups to develop new policies for learning disability services which impact beyond own work area).
<b>8+ Modern Matron Community (Generic)</b>	Responsible for policy implementation and development of a service. (Develops and implements integrated care policies across primary and acute settings).

## **7.1 Data analysis stage 1 – *A priori* theoretical categories**

7.1.1 The first stage in the data analysis process involved the formulation of *a priori* theoretical categories (see *Table 7b*). The rationale for *a priori* categories was discussed in chapter 4. These categories were based on the FPH's key areas of public health (see *Box 1a*), *National profiles of community learning disability nurses* (see *Tables 2c and 7a*) and the *NHS knowledge and skills framework* (see *Table 2d*).

Table 7b: *Priori* theoretical categories

Category	Sources
Healthcare Access	UK Faculty of Public Health  UK knowledge and skills framework  UK National profiles of community learning disability nurses
Health Education	
Health Promotion	
Health Protection	
Health Surveillance	

## 7.2 Data analysis stage 2 – word frequencies

7.2.1 The second stage in the data analysis process involved the use of NVivo8 to undertake word frequency searches (see *Appendix 7a*). Following systematic frequency word searches, terms, which were relevant to the *a priori* theoretical categories, and those which related to generic public health policy, or health elements of policy initiatives for people with learning disabilities were extracted.

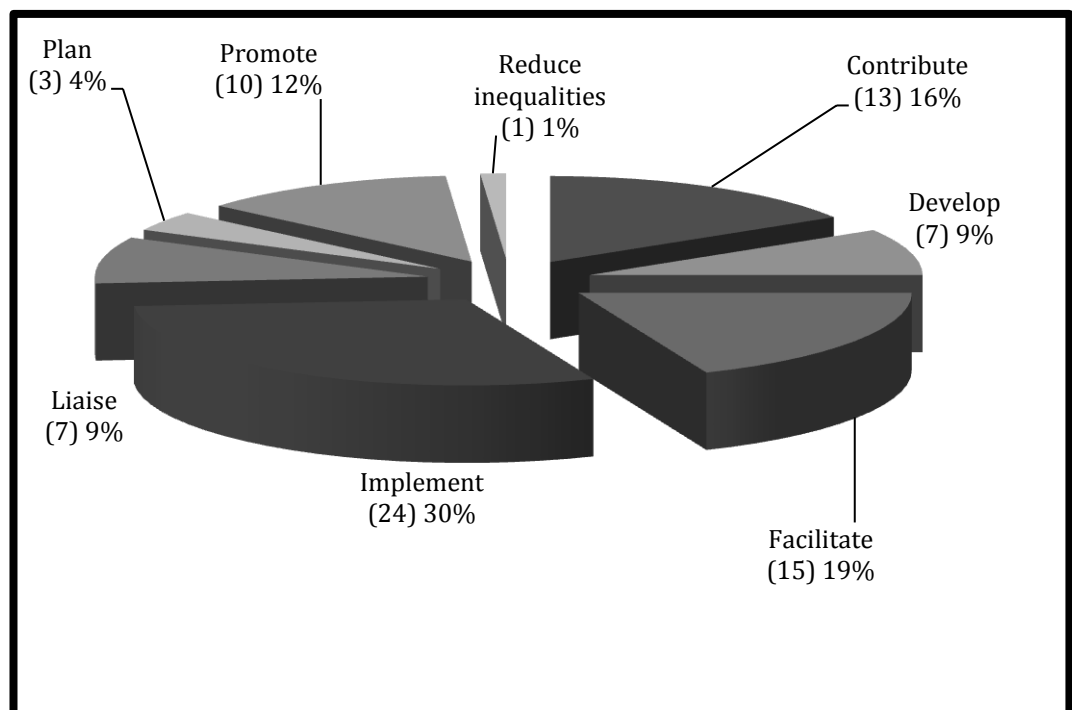
## 7.3 Data analysis stage 3 – Free nodes

7.3.1 The third stage in the data analysis process involved single, Boolean, and proximity searching of the terms identified in data analysis stage 2. From this process there were 3 outputs. Initially, a list of initial free nodes was produced (see *Appendix 7b*). Following this, it was possible to use initial free nodes to chart public health roles and policy involvement for each of the community learning disability nurse bands. For ranked summaries of roles, and policies see *Appendix 7c* and *Appendix 7d* respectively. Finally, I extracted the initial codes (roles and policy) '*in vivo*' as presented in this chapter.

### 7.3.2 **Band 5 nurses' public health roles**

7.3.2.1 *Figure 7a* shows how band 5 community learning disability nurses were expected to fulfil their public health roles. Band 5 roles were within the implementation phase of the policy cycle through implementing, facilitating, contributing, promoting, liaising, planning, and reducing inequalities.

*Figure 7a* Band 5 nurses' public health role expectations ( $n = 63$ ).



7.3.2.2 **Implement (30%).** Evidence from the job descriptions, and person specifications show that band 5 community learning disability nurses were predominantly expected to undertake policy implementation from a variety of perspectives.

Within this role the main focus was on health promotion work or other related activities. Band 5 community learning disability nurses were expected to;

***'Implement*** specialist nursing input relating to individual care plans, for

example **specialist health education, health promotion work**. Plan, **implement and contribute to health promotion / education** group and workshops for adults with a learning disability and their carers, families and support networks' (JD5BE),

'Plan, **implement, and contribute to health promotion / education** group and workshops for adults with a learning disability and their carers, families, and support networks' (PS5W),

'...**undertake health education, and promotion** on a range of learning disability specific and non specific health issues with service users, family members and/or carers' (JD5H),

'participate and **deliver training / education of service users**, carers, professional carers, PCT staff etc. **promoting the health needs of the learning disability service users**...Develop, participate, and deliver specialist teaching sessions, and facilitate learning and development of service users/families/professionals' (JD5LPFT),

'...**undertake health education, and promotion** on a range of learning disability specific and non specific health issues with service users, family members and/or carers' (JD5W),

'...**promote a healthy environment for residents in respect of: Healthy eating; Regular exercise; Health education; Health Screening**' (JD5C), and,

'...**undertake health promotion work** with people with learning disabilities and their carers e.g. healthy eating and health screening' (JD5TH).

The second expectation was that band 5 community learning disability nurses participate in activities related to health action plans and health facilitation as



in the examples below. Band 5 community learning disability nurses were expected to;

*‘...formulate and **implement health action plans** and nursing care plans in partnership with service users, paid and unpaid carers, other professionals and agencies within the context of a recognized conceptual model of nursing to promote optimum good health’* (JD5OLDT),

*‘...assess, plan, **implement and evaluate healthcare with clinical supervision, to promote the health of the individual with a learning disability**’* (JD5TH), and,

*‘**Undertake the health facilitator function as appropriate, formulate and implement health action plans** in partnership with people with learning disabilities, their carers, other professionals and agencies....’*

and *‘To **undertake health promotion work** with people with learning disabilities and their carers e.g. healthy eating and health screening’* (JD5TH).

The third expectation was that band 5 community learning disability nurses implement public health policies through team working with GPs, and facilitating, and enabling access to screening services as in these examples;

*‘To work closely with the Community Learning Disability Team e.g. **joint screening clinics** for GP’s and GP Practices and **pilot some initiatives at selected GP Practices and evaluate to roll out across all GP Practices**’* (JD5ES);

*‘**Facilitate access** for children / adolescents with a learning disability to **physical health surveillance / screening services**’* (JD5O); and,

*‘**Carry out screening tests**’* (JD5WS).

7.3.2.3 **Facilitate (19%).** The second most prominent expectation was that band 5 community learning disability nurses undertake health facilitation predominantly in two contexts. The first context related to an expectation that nurses would;

***‘Facilitate policy related to health as stated in Valuing People...and support person centred planning initiatives’*** (JD5BE),

***‘...work...with health colleagues in primary care to establish health checks for people with learning disabilities’*** (JD5B),

***‘...work in partnership with primary healthcare, service users and learning disability services to facilitate open and easy access to primary healthcare for people with a learning disability’*** (JD5B),

work ***‘...in partnership with primary healthcare to facilitate the smooth running of health facilitation incorporating objective 5 of Valuing People.’*** (JD5FB),

***‘...work in partnership with individuals, families and/or carers to develop individualised health action plans. To facilitate primary healthcare professionals awareness and effectiveness of these plans’*** (JD5H),

***‘...facilitate access to generic services where possible and to act as a link person for primary and acute care health services...To facilitate and promote people with learning disabilities understanding of their own healthcare needs (health promotion role)’*** (JD5K),

***‘Facilitate access for children/adolescents with a learning disability to physical health surveillance/ screening services’*** (JD5O), and,

***‘...facilitate access to health services through collaboration and***

*partnership with primary and secondary health, and other relevant services’ (JD5TH).*

The second facilitation was expected in the context of providing advice to service providers and to service users (health advocacy role), as in the following examples;

*‘Facilitate the public health agenda by providing advice, education and guidance. Act as a health facilitator within the health action planning process’ (JD5LPFT); and,*

*‘Actively promote awareness of health related needs **to facilitate health enhancing activities** and influence policies that effect the health of the identified population’ (JD5CL).*

7.3.2.4 **Contribute (16%).** The third most common expectation was that band 5 community learning disability nurses contribute to public health policy implementation predominantly in the context of health action plans, health promotion, health education, specialist clinics, and broad general health issues. In the first context band 5 community learning disability nurses were expected to;

*‘...participate in a multi-disciplinary approach to meeting healthcare needs and **contribute to individualised health action planning**’ (JD5H1),*

*‘...participate in a multi-disciplinary approach to meeting healthcare needs and **contribute to individualized health action planning**’ (JD5H, JD5W), and,*

*‘...participate in a multidisciplinary approach to meeting healthcare needs and **contribute to individualized health action planning**’*

(JD5W).

In the second context band 5 community learning disability nurses were expected to;

*‘Plan, implement and **contribute to health promotion/education** group and workshops for adults with a learning disability and their carers, families and support networks’ (PS5W).*

In the third context band 5 community learning disability nurses were expected to;

*‘**Contribute to the development of specific aspects of nursing care, including the development of specialist clinics run in partnership with mainstream health services** (e.g. epilepsy clinic, audiology clinic, diabetes project)’ (JD5TH).*

In the fourth context band 5 community learning disability nurses were expected to;

*‘...monitor the health and well-being of groups and individuals and **contribute to protecting those groups and individuals** whose health and well-being is at risk’ (JD5M).*

In the fifth context band 5 community learning disability nurses were expected to;

*‘...**contribute to the health related issues** in the compilation of residential action plans and care plans including where appropriate advice, implementation and monitoring of risk assessments, relating to health matters, promoting a child focused approach to care’ (JD5N).*

7.3.2.5 **Promote (12%)**. The fourth expectation for band 5 community learning disability nurses was that they would undertake health promotion activities in the context of access to services and working with individuals with learning

disabilities. In the first context band 5 community learning disability nurses were expected to;

*‘...contribute to the planning and implementation of training programmes to **promote access to primary care and good health** for people with learning disabilities’ (JD5B), and,*

*‘**Promote and facilitate access to primary and secondary healthcare** for individuals with a learning disability’ (PS5W).*

In the second context band 5 community learning disability nurses were expected to;

*‘...**promote the health and well being of clients** by providing specialist nursing assessment and advice to clients, carers and other professionals’ (JD5B),*

*‘**Promote health education** in children and their families/carers’ (JD5B1),*

*‘Assist service users to maintain and **promote their physical wellbeing**, coexisting within the Valuing people and National service frameworks’ (JD5N),*

*‘...**promote healthy lifestyles** and implement therapeutic programmes within the framework of the NMC Scope of professional practice’ (PS5K),*

*‘...actively **promote health education** for service users’ (JD5SMHSCFT), and,*

*‘...use nursing skills in working with people with learning disabilities to maintain, **promote and improve health**’ (JD5TH).*

7.3.2.6 **Develop (9%)**. Band 5 community learning disability nurses were expected

to develop health action plans, effective systems of liaison, and a learning environment for service users. In the first context band 5 community learning disability nurses were expected to;

*‘...work in partnership with individuals, families and/or carers to **develop individualized health action plans**...facilitate primary healthcare professionals awareness and effectiveness of these plans’* (JD5H), and,

*‘...assess, plan and **develop therapeutic interventions, Health Action Plans**, care plans, and risk assessments under the supervision of a senior nurse’* (JD5K).

In the second circumstance band 5 community learning disability nurses were expected to;

*‘**Develop and maintain effective systems of liaison** with Primary and Secondary services to upgrade/maintain they physical health of clients’* (JD5B),

and, in the third context band 5 community learning disability nurses were expected to;

*‘**Develop, participate and deliver specialist teaching sessions and facilitate learning and development of service users / families / professionals**’* (JD5LPFT).

**7.3.2.7 Liase (9%).** Another significant expectation for band 5 community learning disability nurses in the job descriptions and person specifications was health liaison. This was without exception in the context of health action planning, or health facilitation. In this context band 5 community learning disability nurses were expected to;

*‘...liaise with other members of the Learning Disability Team and other agencies, families and carers to support the development of health action plans for people with learning disabilities incorporating specialist individual treatment plans and goals’ (JD5K; JD5MA).*

7.3.2.8 **Plan (4%).** Band 5 community learning disability nurses were expected to participate in planning in the context of health action plans and in the context of health promotion, or health education activities.

In the first circumstance band 5 community learning disability nurses were expected to;

*‘...assess, **plan** and develop therapeutic interventions, **Health Action Plans**, care plans, and risk assessments under the supervision of a senior nurse’ (JD5K),*

and, in the second context they were expected to;

*‘**Plan**, implement and contribute to **health promotion / education** group and **workshops** for adults with a learning disability and their carers, families and support networks’ (JD5BE; PS5W).*

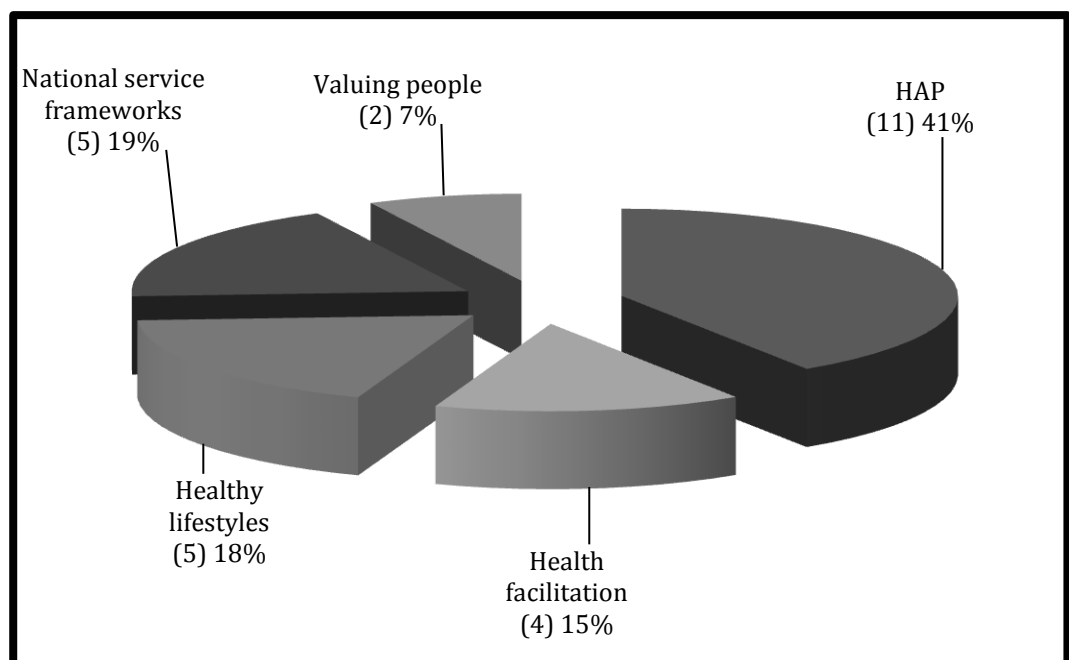
7.3.2.9 **Reduce inequalities (1%).** The last relevant public health role expectation for band 5 community learning disability nurses related to their involvement with reducing inequalities and barriers to accessing services. In this example band 5 community learning disability nurses were expected to;

*‘...support initiatives in identifying and reducing barriers to healthcare’ (JD5TH).*

### 7.3.3 ***Band 5 nurses policy implementation involvement***

7.3.3.1 *Figure 7b* illustrates the policies, or policy areas band 5 community learning disability nurses were expected to be involved in as per the job descriptions and person specifications. Predominantly band 5 community learning disability nurses' involvement with the public health policy process was in the implementation phase.

*Figure 7b:* Band 5 job descriptions policy references ( $n = 63$ ).



7.3.3.2 ***Health action plans (41%)***. The most commonly cited policy / strategy in band 5 job descriptions and person specifications relevant to meeting the public health needs of people with learning disabilities was health action planning. In terms of the policy process, policy implementation was the dominant activity. However, band 5 community learning disability nurses were also expected to participate in monitoring and evaluation of the effectiveness of this strategy.



In the context of health action planning policy implementation band 5 community learning disability nurses were expected to;

*‘...promote and assist service users, parents / carers and social care staff in the use of **level one health action plans**’ (JD5B),*

*‘...participate in a multi-disciplinary approach to meeting healthcare needs and **contribute to individualised health action planning**’ (JD5H2),*

*‘...assess, plan and develop therapeutic interventions, **health action plans**, care plans, and risk assessments under the supervision of a senior nurse’ (JD5K),*

*‘Facilitate the public health agenda by providing advice, education and guidance. **Act as a health facilitator within the health action planning process**’ (JD5LPFT),*

*‘...liaise with other members of the learning disability team and other agencies, families and carers to support the **development of health action plans** for people with learning disabilities incorporating specialist individual treatment plans and goals’ (JD5MA),*

*‘...formulate and **implement health action plans** and nursing care plans in partnership with service users, paid and unpaid carers, other professionals and agencies within the context of a recognized conceptual model of nursing to promote optimum good health’ (JD5O);*

*‘Undertake the health facilitator function as appropriate, formulate and **implement health action plans** in partnership with people with learning disabilities, their carers, other professionals and agencies’ (JD5TH), and,*

*‘...participate in a multi-disciplinary approach to meeting healthcare needs and contribute to individualised health action planning...To work in partnership with individuals, families and/or carers to develop individualised **health action plans**...To facilitate primary healthcare professional awareness and effectiveness of these plans’ (JD5W).*

In the second circumstance band 5 community learning disability nurses were expected to;

*‘**Monitor health action planning** provision and use, including the quality of the plans’ (JD5ES), and,*

*‘Devise(s), **implement(s) and evaluate(s) Health Action Plans** as defined within the nursing role for that activity’ (JD5S).*

**7.3.3.3 National service frameworks (19%).** Although references to *National service frameworks* was the second most commonly cited public health initiatives, the involvement of band 5 community learning disability nurses with these frameworks was ambiguous, and vague as in these four examples;

*‘Contribute to the **implementation of NICE guidelines, National service frameworks** where applicable’ (JD5B);*

*‘**Knowledge of** key policies relating to learning disability (**including NSF, and patient engagement**)’ (JD5ES);*

*‘Assist service users to maintain and promote their physical wellbeing, coexisting within the **Valuing people and National service frameworks**’ (JD5NDS);*

*‘**Contribute to** wider community health services initiatives as required i.e. Essence of care, **NSF implementation groups**’ (JD5TH); and,*

*'The service works in line with the key themes of and Every child matters (2003), the National service framework for children (2004) and Valuing people (DoH 2001)'* (JD5CL).

7.3.3.4 **Healthy lifestyles (18%).** As with *National service frameworks* reported above, references to '*Healthy lifestyles*' were ambiguous as to what band 5 community learning disability nurses' roles were, in the context of the policy process. The following examples suggest that band 5 community learning disability nurses were expected to participate in implementing the policy broadly by 'promoting' healthy lifestyles;

*'To promote a healthy environment for residents in respect of **healthy eating**'* (JD5C);

*'To promote a healthy lifestyles'* (JD5H2; JD5W);

*'To promote healthy lifestyles and implement therapeutic programmes within the framework of the NMC Scope of professional practice'* (JD5K); and,

*'To undertake health promotion work with people with learning disabilities and their carers e.g. **healthy eating** and health screening'* (JD5TH).

7.3.3.5 **Health facilitation (15%).** On the whole, where references were made to health facilitation, it was clear that band 5 community learning disability nurses were expected to assume the health facilitator role as can be seen in these examples;

*'Facilitate the public health agenda by providing advice, education and guidance. **Act as a health facilitator within the health action planning process**' (JD5LPFT);*

*'To provide a robust health framework for the older people who use the day service by completing health assessments, creating care plans to address any health needs and **acting as a health facilitator**' (JD5OFT); and,*

*'**Undertake the health facilitator function** as appropriate, formulate and implement health action plans in partnership with people with learning disabilities, their carers, other professionals and agencies.....Within the health facilitator process, contribute to work with mainstream services to support them to develop the necessary skills required to meet the health needs of people with learning disabilities' (JD5TH).*

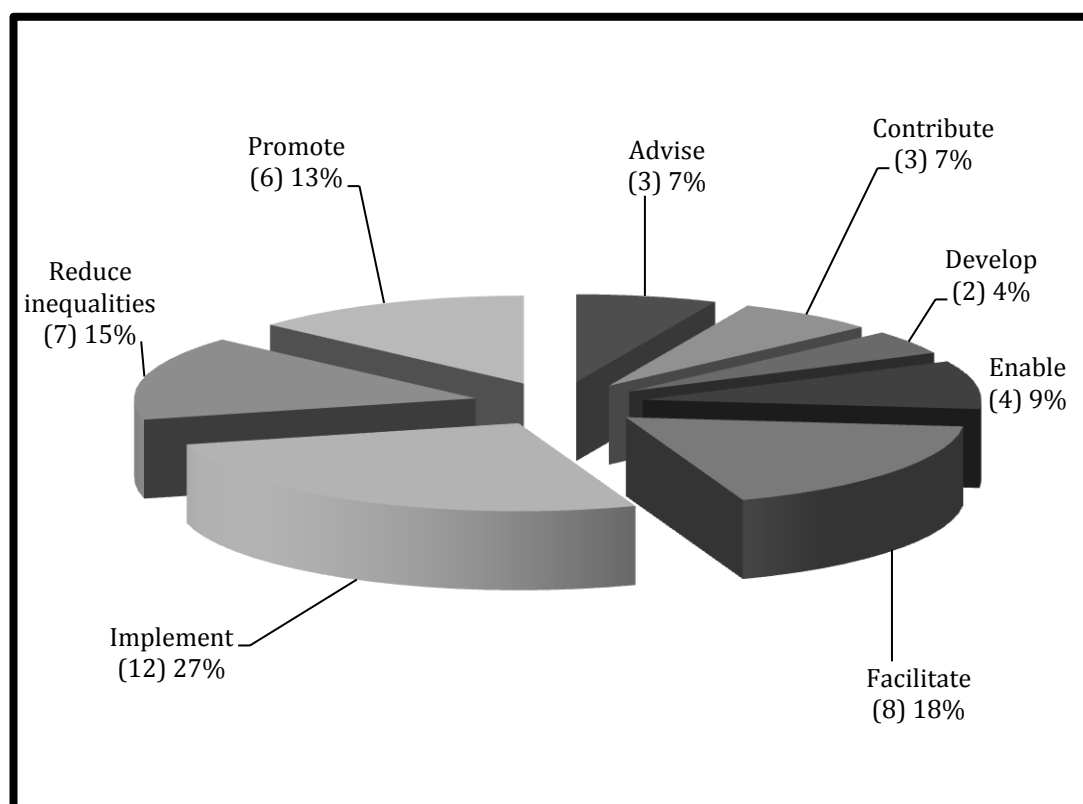
7.4.3.6 **Valuing people (7%)**. Like the other references made to relevant policies with implications for the public health roles of community learning disability nurses, expectations for band 5 community learning disability nurses in relation to the health elements of *Valuing people* (DH 2001) were ambiguous at best. Band 5 community learning disability nurses were expected to;

*'**Facilitate policy related to health as stated in Valuing people**...and support person centred planning initiatives' (JD5BE), and*  
*'**Assist service users to maintain and promote their physical wellbeing, coexisting within the Valuing People and National Service Frameworks**' (JD5NDS).*

### 7.3.4 Band 6 nurses public health roles

7.3.4.1 *Figure 7c* shows how band 6 community learning disability nurses were expected to fulfil their public health roles. Broadly, band 6 roles were expected within the implementation phase of the policy cycle through practical implementation, facilitation, reducing inequalities, health promotion, enabling other clinicians and people with learning disabilities, providing advice, contributing to the delivery of public health policy programmes, and developing packages and pathways.

*Figure 7c:* Band 6 nurses' public health role expectations ( $n = 87$ ).



7.4.4.2. **Implement (27%).** For band 6 community learning disability nurses, the most common public health role was in the practical implementation of the relevant policies or strategies. The roles cited included implementing health

action plans, screening, and health facilitation, providing advice, health promotion, and health education. In the context of health action planning, health screening, and health facilitation, band 6 community learning disability nurses were expected to;

*‘...**implement health action plans** for clients’ (JD6H),*

*‘**Implement health action plans** for people with learning disabilities, living within the boundaries of the N.... & S...PBC cluster’ (JD6N),*

*‘**Implement health action plans** for people with learning disabilities, living within the boundaries of N.... City’ (JD6CNHF),*

*‘Directly assist others to develop and **implement accessible models of individual health action plans** in partnership with service-users, CLDT colleagues and primary care staff’ (JD6B1), and,*

*‘...engage with primary care teams and support them to initiate, contribute to, and **implement health action plans** for people with learning disabilities’ (JD6E).*

In the context of providing advice, health promotion, and health education, band 6 community learning disability nurses were expected to;

*‘...**provide advice** and support to promote good health and well being to primary and secondary healthcare professionals, individuals with learning disabilities, their families, carers, statutory and voluntary care service providers’ (JD6K),*

*‘**Provide pro-active health promotion** advice and guidance to clients and their carers’ (JD6SY),*

*‘...be responsible for the clinical support required to **provide Health Screening and Health facilitation**’ (JD6B1),*

*'Directly **implement interventions aimed at improving health outcomes**, while at other times co-ordinating the involvement of others, and provide information, advice and education in support of the healthcare plan where this is required'* (JD6H1), and,  
*'**Provide effective teaching to individual patients and their families**'* (JD6H).

7.3.4.2 **Facilitate (18%)**. Role expectations within the '*facilitation*' role for band 6 community learning disability nurses focused primarily on facilitating health checks through working with primary care staff, and with people with learning disabilities. Band 6 community learning disability nurses were expected to;

*'...**facilitate health checks** for all the patients identified in the GP QOF, using an agreed health tool to identify gaps in current healthcare'* (JD6CNHF),

*'Provide support to GP practices within the health access QOF, to identify their patients with a learning disability', and '**To facilitate health checks** for all the patients identified in the GP QOF, using an agreed health tool to identify gaps in current healthcare'* (JD6N),

*'Working in collaboration with the Primary Healthcare Teams to **facilitate health screening** and undertake health promotion initiatives in line with the Health of the Nation Strategy'* (JD6E), and,

*'...work in partnership with people with a learning disability, their families and carers, using communication skills effectively to **facilitate clients' understanding of health issues**'* (JD6W).

7.3.4.3 **Reduce inequalities (15%).** Band 6 community learning disability nurses were expected to work with other primary healthcare agencies in order to reduce health inequalities experienced by people with learning disabilities by facilitating access to health services including public health services. In enacting this role band 6 community learning disability nurses were expected to;

*‘Establish a partnership approach with local primary care services to achieve the objective of health assessments and health interventions that **reduce health inequalities**’ (JD6B1), and,*

*‘...work in collaboration with the various primary care agencies to improve health outcomes, **ensure equity of access to health services** and undertake health promotion activities’ (JD6H).*

7.3.4.4 **Promote (13%).** In the job descriptions and person specifications analysed in this study, band 6 community learning disability nurses were expected to engage in promoting health in a number of ways. Firstly, in order to function in this role there was an expectation that incumbents of this role needed to have prior;

*‘**Experience of leading activities that promote health and wellbeing**’ (PS6NEL).*

Secondly, band 6 community learning disability nurses were expected to;

*‘...**promote good health and well being** to primary and secondary healthcare professionals, individuals with learning disabilities, their families, carers, statutory and voluntary care service providers...**promote healthy lifestyles** and implement therapeutic programmes within the framework of the NMC Scope of Professional*



*Practice...work in partnership with care provider services, families and carers, to offer advice and support to assist them **to promote and maintain optimum levels of physical and mental health for individuals and groups of people with learning disabilities.***

(JD6K),

*'Devise, evaluate, and contribute to the planning and implementation of therapeutic and highly complex programmes of care in order to **promote the health and wellbeing of clients***' (JD6ABMUT), and,

*'Utilise specialist nursing skills to support people with a Learning Disability and their carers to **maintain and improve health and well being***' (JD6R).

In the third context, band 6 community learning disability nurses were expected to;

*'**Promote access to health services** for people with a learning disability through collaboration and partnership working, and the use of health facilitation and health action plans'* (JD6R), and,

*'**Promote and facilitate access to primary and secondary healthcare** for individuals with a learning disability'* (JD6BW).

In the fourth context, band 6 community learning disability nurses were expected to;

*'**Implement programmes of care in the education** of children / families / carers, **which minimise ill health and help attain optimum health potential***' (JD6BNH).

7.3.4.5 **Enable (9%)**. Band 6 community learning disability nurses were expected to enable people with learning disabilities and others in one of two ways.

The first context was clearly outlined and band 6 community learning disability nurses were expected to;

*'Where **appropriate educate clients**, parents / carers regarding health related issues using evidence based information' (JD6B),*

*'...**advise and educate clients**, carers, and relatives (as appropriate), on the implementation of care plans' (JD6SGL), and,*

*'**Educate service users**, carers and others involved in the care of adults with a learning disability including health action planning, health facilitation, health screening and learning disability awareness' (JD6S).*

In the second circumstance the expectation was ambiguous as to how band 6 community learning disability nurses were expected to enable people with learning disabilities as is shown in this example;

*'**To enable and empower individuals to access services** and actively contribute to decisions which affect the quality of their lives' (JD6E).*

7.3.4.6 **Advise (7%).** Band 6 community learning disability nurses were expected to advise people with learning disabilities, relatives and carers on specific and general health issues. In the first context band 6 community learning disability nurses were expected;

*'**To advise and educate clients**, carers, and relatives (as appropriate), on the implementation of care plans' (JD6SGL).*

In the second context band 6 community learning disability nurses were expected to;

*'**Advise service users**, carers and others involved in the care of adults with a learning disability including **health action planning, health***

***facilitation, health screening and learning disability awareness'***

(JD6S).

The third context was rather ambiguous as to whether references to 'health related issues' included public health or not, such as in this example;

***'Where appropriate advise clients, parents/carers regarding health related issues using evidence based information'*** (JD6B2).

7.3.4.7 **Contribute (7%)**. In the first context, band 6 community learning disability nurses were expected to;

***'...engage with primary care teams and support them to initiate, contribute to, and implement health action plans for people with learning disabilities'*** (JD6E).

In the second context, where there appeared to be some relevance for the current study, band 6 community learning disability nurses were expected to;

***'...make independent decisions and contribute to the diagnosis, care / treatment of children and families in the area of specialist CAMHS'*** (JD6L).

Although it was not apparent in this example, working with children with mental health needs predominantly fits in with the *NSF* for mental health, and *NSF* for children which both are broad public health policy initiatives.

7.3.4.8 **Develop (4%)**. In the first context band 6 community learning disability nurses were expected to,

***'...develop health action plans (HAPS) based on the information gathered from the comprehensive health assessments ensuring that***

*these plans are recorded fully for each service user’ (JD6C),*

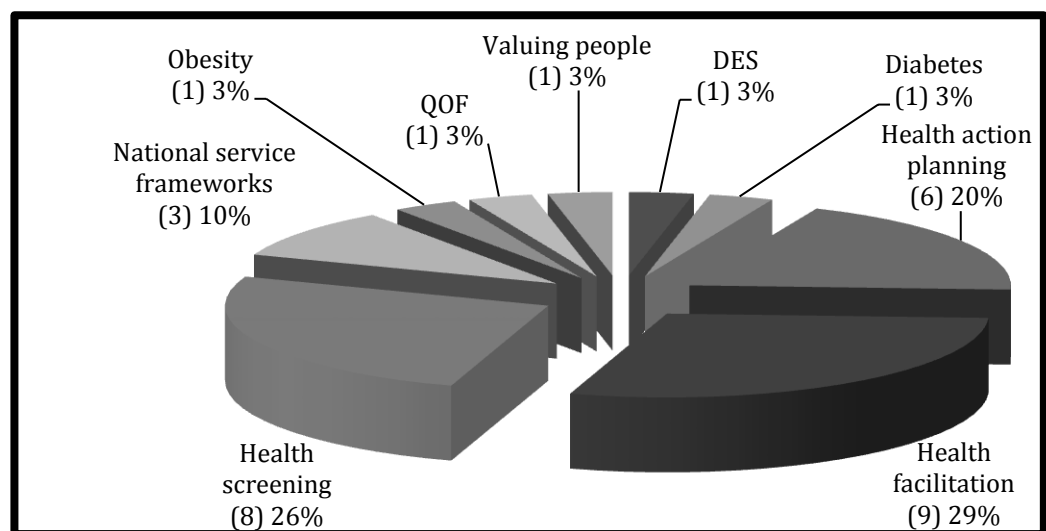
and, in the second context they were expected to;

*‘...identify, develop, implement and evaluate health facilitation research for the learning disabilities service’ (JD6B1).*

### 7.3.5 Band 6 nurses policy implementation involvement

7.3.5.1 *Figure 7d* illustrates the policies or public health initiatives band 6 community learning disability nurses were expected to be involved in as per the job descriptions and person specifications. Predominantly band 6 community learning disability nurses’ involvement with the public health policy cycle was in the implementation phase with minor but significant references to involvement in policy evaluation.

*Figure 7d: Band 6 job descriptions policy references (n = 87).*



7.3.5.2 **Health facilitation (29%).** The expected involvement of band 6 community learning disability nurses with the health facilitation strategy was predominantly in the implementation phase, and to a lesser extent in the evaluation of the policy. In the context of implementing the health

facilitation strategy, band 6 community learning disability nurses were expected to;

*‘...lead and actively promote the **effective implementation of Health Facilitation** for people with learning difficulties in ... using person centred approaches....To be responsible for the clinical support required to provide health screening and health facilitation’ (JD6B1),*

*‘Support the **development of health facilitation**, reflecting local user’s views, national best practice approaches and local demographic needs. Implementing and co-ordinating publicity, training and advice on this development’ (JD6CNHF),*

*‘...work in collaboration with primary care teams and other stakeholders in the **development and implementation of** health action plans and **health facilitation** to ensure optimal physical and mental health outcomes for the learning disabled’ (JD6M),*

*‘**Promote** access to health services for people with a Learning Disability through collaboration and partnership working, and **the use of health facilitation** and health action plans’ (JD6R),*

*‘...lead in developing and establishing a new project within SG for people with learning difficulties (PWLD), to improve their access to and experience of primary care services....actively **promote health facilitation** for PWLD and provide direct clinical leadership and support to CLDT staff and identified health facilitators’ (JD6SG),*

*‘...**provide advice and** input around issues such as behavioural work, crisis intervention, continence issues, sexuality and personal relationships, epilepsy, health action plans and **health facilitation**, anger management, dementia screening’ (JD6O), and,*

*‘...be responsible for the clinical support required **to provide** health screening and **health facilitation**’ (JD6B1).*

In the second context band 6 community learning disability nurses were expected to participate in the;

*‘...**evaluation** of evidence based practice within.... hospital divisions and community learning disability teams **relating to health facilitation**’ (JD62GNHST).*

7.3.5.3 **Health screening (26%).** The expected involvement of band 6 community learning disability nurses with health screening was in the implementation phase of the policy cycle through providing health screening, supporting the development of health screening, facilitating health screening, facilitating uptake of screening services, and through developing and implementing health screening tools. Examples of how band 6 community learning disability nurses were expected to implement health screening were as follows;

*‘To be responsible for the clinical support required to **provide Health Screening** and **Health facilitation**’ (JD6B1);*

*to ‘...**support Strategic Lead on development of health screening** and the use of Health Action Plans for people with learning disabilities across Primary Care in each of three localities in NC’ (JD6CNHF);*

*‘...to **facilitate health screening** and undertake health promotion initiatives in line with the Health of the Nation Strategy’ (JD6E1);*

*‘The Learning Disabilities Health Facilitator’s team will support primary care with the development of learning disabilities risk registers development of personal health action plans **enabling greater uptake***

*of health screening services and supporting the implementation of the directed enhanced service for learning disabilities’ (JD6N); and,*

*‘Develop an appropriate health screening tool for early identification of health need, liaison with Primary Healthcare services and the development of support systems required to provide consistent evidence of Primary Healthcare management of key conditions with recall and follow-up via regular health checks’ (JD6SG).*

7.3.5.4 **Health action planning (20%).** The expected involvement of band 6 community learning disability nurses with the health action planning strategy process involved predominantly implementation, and to a lesser extent in the evaluation of the policy. In the context of policy implementation band 6 community learning disability nurses their involvement included;

*supporting ‘...primary care with the development of learning disabilities risk registers **development of personal health action plans** enabling greater uptake of health screening services and supporting the implementation of the directed enhanced service for learning disabilities’ (JD6CNHF),*

*working ‘...in collaboration with primary care teams and other stakeholders in the **development and implementation of health action plans** and health facilitation to ensure optimal physical and mental health outcomes for the learning disabled’ (JD6M),*

*supporting ‘...**Strategic Lead on development of** health screening and the use of **health action plans** for people with learning disabilities across primary care in ..... & .....localities’ (JD6N),*

promoting ‘...**access to health services** for people with a learning disability **through** collaboration and partnership working, and the use of health facilitation and **health action plans**’ (JD6R), and, ensuring ‘...**the provision of effective health action plans** across all learning disability care providers within Leicestershire, including health home campuses, social care and independent providers. **Providing highly specialist support, advice and guidance in relation to developing and implementing person centred health action plans** whilst promoting equal access to mainstream health services for people with a learning disability’ (JD6LR).

In the context of policy evaluation band 6 community learning nurses were expected to;

‘...be responsible for assessment of health needs, **implementation and evaluation of health action plans**’ (JD6E).

7.3.5.5 **National service frameworks (NSFs) (10%).** The fourth most commonly cited policy relevant to the delivery of public health services for people with learning disabilities in which band 6 community learning disability nurses were expected to be involved in was NSFs. Their expected involvement was in the context of implementation in the policy process such as in the following examples;

‘**Support the delivery of the NHS continuing healthcare (CHC) and NHS-funded nursing care (FNC), National service framework (NSF)**..... An awareness of relevant health and social care policies including **NSF for older people** and Intermediate care NHS and local council responsibilities’ (JD6B1);



*‘Assists the Service Manager in developing a service that meets the requirements of the **children’s National service framework** and other national guidance’ (JD6NY); and,*

*‘To work with the locality CAMHS managers in **developing local protocols and effective care pathways** for children/ young people with a mental health and learning disability diagnosis as provided in the **National Service Framework**’ (JD6T).*

7.3.5.6 **Obesity (3%)**. Band 6 community learning disability nurses’ expected involvement with the policy on obesity was in the implementation phase of the policy process, and they were expected to;

*‘Liaise with mainstream school nurses to share information and ensure best practice in service development and delivery. This will include national programme management for example **obesity** and immunisation planning’ (JD6BNHSN).*

7.3.5.7 **Diabetes (3%)**. Band 6 community learning disability nurses’ expected involvement with the policy on diabetes was in the implementation phase of the policy process. However in the following example it was ambiguous as to how the nurses were expected to participate in the implementation process such as in this example;

*‘Specialist nursing intervention in specific health conditions such as epilepsy, **diabetes**, and the effects of syndromes’ (JD6N1).*

7.3.5.8 **Quality outcomes framework (QOF) (3%)**. Band 6 community learning disability nurses’ expected involvement with the policy on QOF was in the

implementation phase of the policy cycle. As can be seen in the following example, band 6 community learning disability nurses were expected to participate in the implementation of this policy through providing support to the primary care team, facilitating access for people with learning disabilities, and facilitating health checks;

***‘Provide support to GP practices within the health access QOF, to identify their patients with a learning disability. To facilitate health checks for all the patients identified in the GP QOF, using an agreed health tool to identify gaps in current healthcare’*** (JD6CNHF).

7.3.5.9 **Directed enhanced services (DES) (3%)**. The expectations for band 6 community learning disability nurses’ involvement with DES focused on the implementation phase of the policy cycle as in the following example;

***‘The learning disabilities health facilitator’s team will support primary care with the development of learning disabilities risk registers development of personal health action plans enabling greater uptake of health screening services and supporting the implementation of the directed enhanced service for learning disabilities’*** (JD6CNHF).

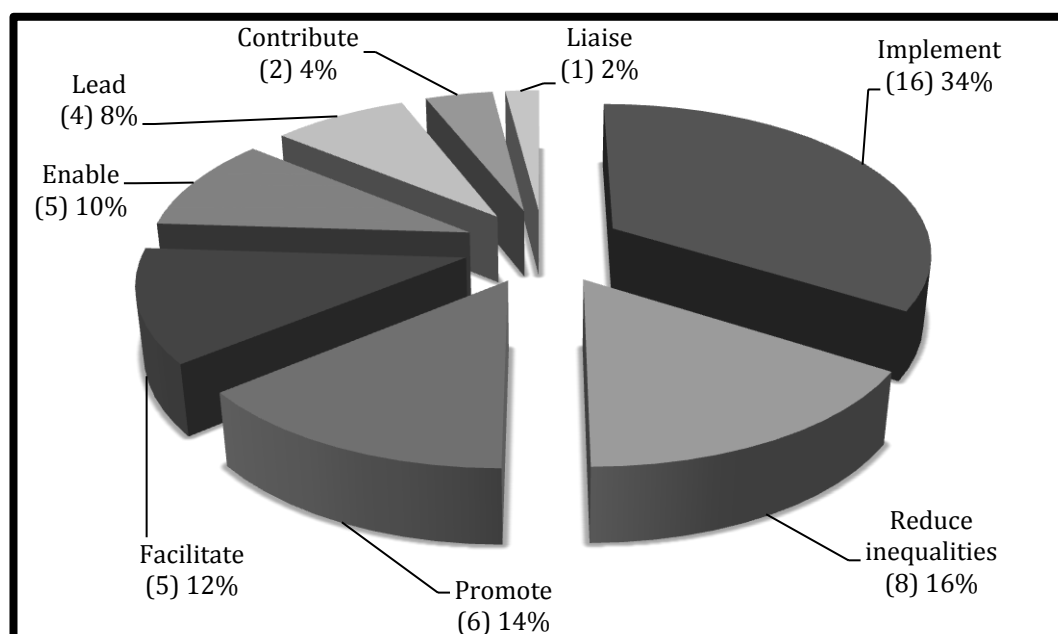
7.3.5.10 **Valuing people (3%)**. Expectations in how band 6 community learning disability were to be involved with implementing the health elements of *Valuing people* (DH 2001) were vague and ambiguous as in the following example;

***‘Understanding of the Valuing People White Paper and Valuing People Now. Understanding of the key health issues for people with learning disabilities’*** (PS6LR).

### 7.3.6 Band 7 nurses public health roles

7.3.6.1 *Figure 7e* shows how band 7 community learning disability nurses were expected to fulfil their public health roles. Broadly, band 7 roles were expected within the implementation phase of the policy cycle through practical implementation, reducing inequalities, health promotion, facilitation, enabling other clinicians and people with learning disabilities, providing advice, leading on specific policy initiatives, contributing to the delivery of public health policy programmes, and engaging in the health liaison role.

*Figure 7e: Band 7 nurses' public health role expectations (n = 47).*



7.3.6.2 **Implement (34%).** Band 7 community learning disability nurses were expected to implement a wide range of initiatives (health action plans, health passports, health promotion, health education, person centred plans, health screening, health surveillance, health facilitation). In addition, they were expected to provide specialist support and advice to other primary care professionals involved in implementing public health initiatives that were

relevant to people with learning disabilities. They were expected to;

*‘...co-ordinate and **implement health action plans** (direct and indirect) and through an advisory role, support generic health professionals in their ‘health facilitation’ role (health visitors, district nurses, practice nurses, therapists, medics, GPs etc.) across all organisations and sectors’ (JD7H),*

*‘**Undertake the health facilitator function**, formulate and **implement health action plans** in partnership with people with learning disabilities, their carers, other professionals and agencies...undertake health promotion work with people with learning disabilities and their carers e.g. healthy eating and health screening’ (JD7TH),*

*‘...**develop and implement health passports**’ (JD7L),*

*‘...assess, plan, **implement and...promote the health of the individual with a learning disability**’ (JD7TH),*

*‘...**establish health education and health promotion initiatives** and support people with LD to draw on such resources...**Establish and deliver training packages** that offer additional support to all service providers and service users **in respect to person centred planning, health screening, health action plan and health improvements initiatives**’ (JD7D),*

*‘...**provide specialist support in identifying and meeting the health needs** of people with learning disabilities’ (JD7BD),*

*‘...**provide an advisory role** for people with learning disabilities (with complex physical health and challenging needs) in the community setting accessing health services’ (JD7H1),*

*‘...provide support to GPs and primary care teams in identifying the practice population of people with a learning disability’* (JD7R),

*‘Establish and deliver training packages that offer additional support to all service providers and service users in respect to person centred planning, health screening, health action plan and health improvements initiatives’* (JD7BD), and,

*‘...undertake or facilitate the active detection of ill health using ethical frameworks, deductive reasoning and analysis to problem solve health concerns moving complex cases forward’* (JD7MEH).

7.3.6.3 **Reduce inequalities (16%).** Band 7 community learning disability nurses were expected to actively reduce inequalities by enhancing and improving access to generic health services, promoting inclusion in generic public health services, preventing ill health, promoting equality of access, improving the quality of life of people with learning disabilities, and working to reduce the adverse impacts of the circumstances of individuals with learning disabilities. They were expected to;

*‘...facilitate and **enhance health access** for adults with learning disability to primary and secondary healthcare within the Borough of BD...lead and support programs **to improve health and well being, reduce inequalities and promote social inclusion...**’* (JD7D),

*‘...liaise with specialists to **improve access to health services** for people with learning disabilities (epilepsy, diabetes, mental health specialists)’* (JD7H),

*‘...lead and support programmes to improve health and well being, **reduce inequalities and promote social inclusion** as discussed in the “Valuing people now” White Paper...**promote equality and diversity in relation to learning disability and ethnicity to reduce inequalities**’ (JD7BD),*

*improve ‘...the quality of life and **reduce health inequalities as identified in the National Service Frameworks**’ (JD7H1),*

*take ‘...a key role in taking forward the health improvement agenda to increase awareness of the wider determinants of health and...**reduce the adverse impact of life circumstances and lifestyles in health and well being**’ (JD7L; JD7PAEL), and,*

*‘...embrace public health role, **promoting health and wellbeing and where possible, prevent ill health**’ (JD7BPCT).*

7.3.6.4 **Promote (14%).** Band 7 community learning disability nurses were expected to fulfil their health ‘promoting’ roles in a variety of contexts. In the first context band 7 community learning disability nurses were expected to;

*‘**Undertake individual work with clients to promote health, responsibility and autonomy and reduce any challenges the client presents**’ (JD7C).*

In the second circumstance they were expected to;

*‘**Promote health through empowering service users to make informed choices about their health needs and the treatment and care they receive**’ (JD7H).*

In other contexts they were expected to;

*‘...**promote awareness of health issues, development of a health profiles, personal health records and health action plans**’ (JD7I, JD7MEHL),*

*‘...use advanced nursing skills in working with people with learning disabilities to maintain, **promote and improve health**’ (JD7TH), and,*

*‘...embrace public health role, **promoting health and well being** and where possible, prevent ill health’ (JD7BPCT).*

7.3.6.5 **Facilitate (12%).** Band 7 community learning disability nurses were expected to facilitate access to primary care services, health screening, health education and health promotion. In the first context nurses were expected to;

*‘...**facilitate and enhance health access** for adults with learning disability to primary and secondary healthcare within the Borough of B...and D...Identify barriers to accessing healthcare services for people with learning disabilities and plan actions and initiatives to overcome and facilitate easy access...**facilitate Directed Enhanced Services (DES) for annual health checks** for people with learning disabilities known to local authority’ (JD7BD).*

In the second context band 6 community learning disability nurses were expected to;

*‘...**facilitate health screening and health action plans and to support practice nurses, GPs and other primary and secondary care services**’ (JD7H).*

In the third context band 7 community learning disability nurses were expected to;

*‘...work closely with primary care services and multi-disciplinary teams to **facilitate health screening checks** for people with a learning disability’ (JD7SY).*

In the fourth context the nurses were expected to;

*‘...undertake or **facilitate the active detection of ill health** using ethical frameworks, deductive reasoning and analysis to problem solve health concerns moving complex cases forward’ (JD7MEHL),*

and, in the fifth context they were expected to;

*‘Provide and **facilitate health education and health promotion** activities for people with learning disabilities in day centres, schools and other establishments’ (JD7TH).*

7.3.6.6 **Enable (10%).** Band 7 community learning disability nurses were expected to enable service users to access appropriate services through the provision of information. Secondly, the nurses were expected to enable members of primary care teams by providing support in order to improve access to appropriate preventative health services. The expectation was primarily on implementation of policy initiatives such as in the following contexts;

*‘To **provide specialist support in identifying and meeting the health needs** of people with learning disabilities...Work in partnership with the community learning disability team and the PCT to participate in the role of the nurse in order to **support the implementation of health-screening and health improvement plans**’ (JD7BD);*



*'To **provide support to GPs and primary care teams** in identifying the practice population of people with a learning disability' (JD7R); and, 'Provide information and **support to clients, their families and carers to enable access to primary and secondary health services**' (JD7TH).*

In addition to implementing public health policy, band 7 community learning disability nurses were expected to evaluate policy such as in the following example;

*'Advise and **support primary care on the development of health check assessments** to be used by GP's and practice nurses.... Advise and **support primary care in their implementation and evaluation of the local and Direct Enhanced Services for people with learning disabilities**' (JD7SY).*

7.3.6.7 **Lead (8%).** Band 7 community learning disability nurses were expected to assume leadership roles in implementing preventative health programs, developing appropriate services, and surveillance as in the following examples;

*'To **lead and support programmes to improve health and well being**, reduce inequalities and promote social inclusion as discussed in the "Valuing People Now" white paper' (JD7BD);*

*'To **lead on the development of health facilitation and health action planning** for people with learning disabilities and to work in collaboration with other colleagues and primary healthcare services to*

*ensure the implementation of the action plans arising from the Health framework and Healthcare for all’ (JD7R); and,*

*‘To **take the lead in the planning and development of shared care with primary and secondary health services** i.e. nurse-led epilepsy clinic, **diabetes care**, audiology, **sexual health and Health Promotion.... To lead on initiatives in identifying and reducing barriers to healthcare’** (JD7TH).*

7.3.6.8 **Contribute (4%).** Band 7 community learning disability nurses were expected to;

*‘**Contribute to the delivery of the recommendations articulated in Equally Well** and the service developments required to address issues raised in recent Fatal Accident Inquiries’ (JD7L), and,*

*‘...**contribute to the development of healthcare information** and resources in accessible formats for service users and their families / carers’ (JD7PAEL).*

7.3.6.9 **Liaise (2%).** Some employers expected band 7 community learning disability nurses to;

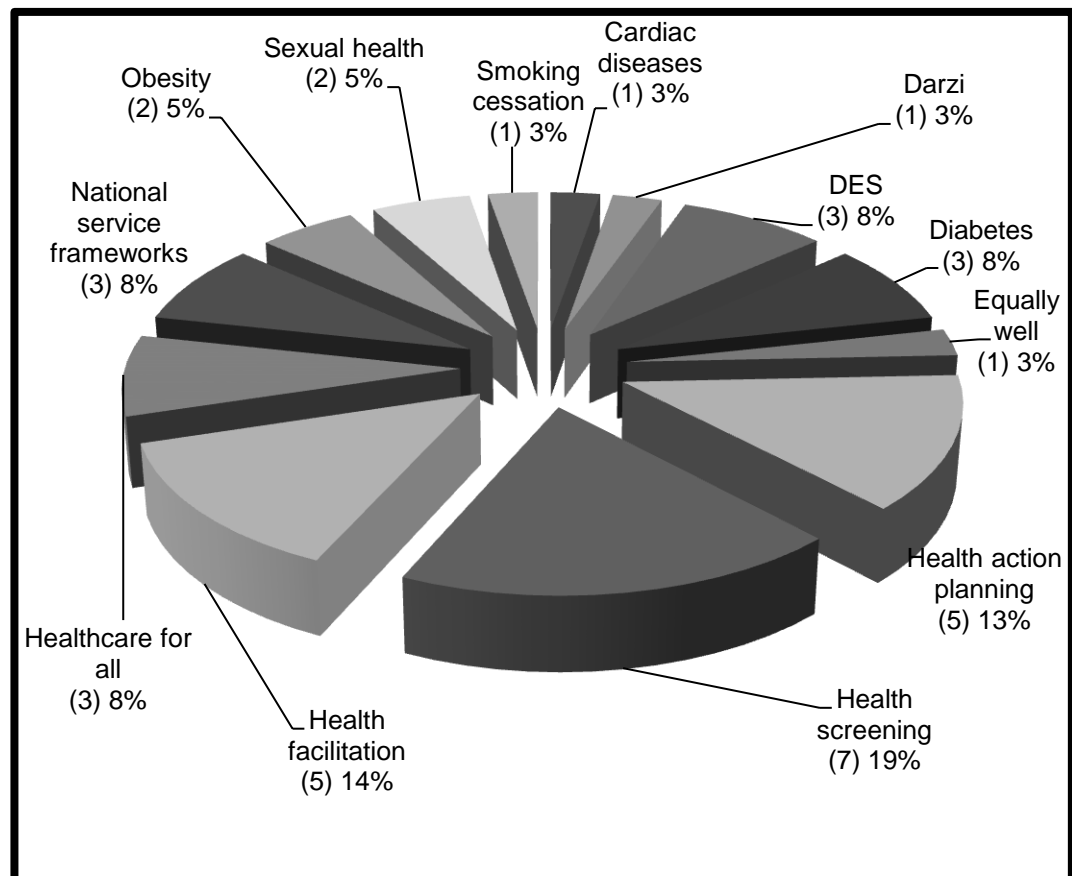
*‘...**liaise with specialists to improve access to health services** for people with learning disabilities (epilepsy, diabetes, mental health specialists)’ (JD7H1).*

### 7.3.7 **Band 7 nurses policy implementation involvement**

7.3.7.1 *Figure 7f* illustrates a wide range of relevant policies, or initiatives band 7 community learning disability nurses were expected to be involved in as per

the job descriptions and person specifications. Predominantly band 7 community learning disability nurses' involvement with the public health policy cycle was in the implementation phase with some significant references to policy evaluation.

Figure 7f: Band 7 job descriptions policy references ( $n = 47$ ).



**7.3.7.2 Health screening (19%).** Health screening was the most widely cited policy in which band 7 community learning disability nurses were expected to have significant involvement. In all contexts such as in the following examples, their involvement was expected to be in the implementation phase of the policy process. The nurses were expected to;

work ‘...in partnership with GPs to ensure all registered service users to have **annual health screening**...audit discriminatory practice in

access to healthcare, including access to **mainstream screening programmes**, i.e., **cervical screening** and acute healthcare and linking to clinical governance responsibilities...Establish and deliver training packages that offer additional support to all service providers and service users in respect to person centred planning, **health screening**, health action plan and health improvements initiatives...Work in partnership with the community learning disability team and the PCT to participate in the role of the nurse in order to support the **implementation of health-screening** and health improvement plans' (JD7BD),

'...set up systems for maintaining and updating learning disability GP registers support practices and health centres to identify who has a learning disability and to provide the **annual health checks** to all clients who wish to have one...To support participating GP's to identify patients' with learning disability and support with the **pre-annual health checks**' (JD7H2),

work '...in partnership with generic health services, service users and carer's to **implement and facilitate health screening** and health action plans and to support practice nurses, GPs and other primary and secondary care services' (JD7H1),

'Work in partnership with health providers to meet targets set in Government documents and the LC partnership board, e.g.: **implementing LD health checks**' (JD7LC),

*‘...be responsible for **implementing** Valuing people (DOH) and Valuing people now which includes health action planning, health facilitation and **health checks** for people with a learning disability’ (JD7NS),*

*‘...work closely with local healthcare services and multi-disciplinary teams to facilitate and where appropriate, **participate in healthcare screening checks** for people with a learning disability’ (JD7R1),*

*‘...undertake health promotion work with people with learning disabilities and their carers e.g. healthy eating and **health screening**’ (JD7TH), and,*

*‘...work closely with primary care services and multi-disciplinary teams to **facilitate health screening checks** for people with a learning disability’ (JD7SY).*

**7.3.7.3 Health facilitation (14%).** Broadly, the expectation here was that band 7 community learning nurses would lead on the implementation of health facilitation, and they were expected to;

*‘...help ensure equal access to mainstream health services for people with a learning disability by involvement in strategic health planning and **developing health facilitation**’ (JD7LC),*

*‘...be responsible for **implementing** Valuing people (DOH) and Valuing people now which includes health action planning, **health facilitation** and health checks for people with a learning disability’ (JD7NS),*

*‘...lead on the **development of health facilitation** and health action planning for people with learning disabilities and to work in collaboration with other colleagues and primary healthcare services to*

*ensure the implementation of the action plans arising from the Health framework and Healthcare for all’ (JD7R),*

*‘...co-ordinate the **implementation of the role of health facilitators**, advise and support the maintenance of health action plans and access to mainstream health services’ (JD7SY), and,*

*‘**Within the health facilitation process**, work with mainstream services to support them to **develop** the necessary skills to meet the health needs of people with learning disabilities’ (JD7TH).*

**7.3.7.4 Health action planning (13%).** Health action planning was the third most cited relevant policy in which band 7 community learning disability nurses were expected to have a significant involvement. The expected involvements were all broadly in the context of the implementation phase of the policy process as demonstrated in the following examples;

*‘To **facilitate, provide advice and support** to individual health centres and practices in the development and delivery of **health action plans**’ (JD7H2);*

*‘To carry out health screening assessments and **produce health action plans** on a monthly basis and to input data/develop and **maintain the health action plan database** and produce reports/statistics etc. when required (in a timely fashion’ (JD7H1);*

*‘To **be responsible for implementing** Valuing People (DOH) and Valuing People Now which includes **health action planning**, health facilitation and health checks for people with a learning disability’ (JD7NS);*

*'To lead on the development of health facilitation and **health action planning** for people with learning disabilities and to work in collaboration with other colleagues and primary healthcare services to ensure the implementation of the action plans arising from the Health framework and Healthcare for All' (JD7R);*

*'Undertake the health facilitator function, **formulate and implement health action plans** in partnership with people with learning disabilities, their carers, other professionals and agencies' (JD7TH);*  
and,

*'He / she will co-ordinate the implementation of the role of Health Facilitators, **advise and support the maintenance of Health Action Plans** and access to mainstream health services' (JD7SY).*

7.3.7.5 **Healthcare for all (8%).** Band 7 community learning disability nurses' involvement with *Healthcare for all* (Michael 2008) was in a number of varying contexts.

In the first context band 7 community learning disability nurses were expected to;

*'...establish systems which will ensure that vulnerable patients, and people with learning disabilities in particular, are identified and appropriately supported as outlined in the Next stage review (2008), Valuing people now (2008) and '**Healthcare for all**' (2008)' (JD7I).*

In the second context band 7 community learning disability nurses were expected to;

***‘...lead on the development of health facilitation and health action planning for people with learning disabilities and to work in collaboration with other colleagues and primary healthcare services to ensure the implementation of the action plans arising from the Health framework and Healthcare for all’ (JD7R1).***

In the third circumstance the nurses were expected to;

***‘Advise and support the acute trust in the implementation of recommendations as outlined in national policy/guidance – ‘Healthcare for all’ and Darzi review, specifically related to learning disability’ (JD7SY).***

**7.3.7.6 National service frameworks (NSFs) (8%).** Band 7 community learning disability nurses were expected to be involved with NSFs in the context of policy implementation and in the context of policy evaluation. In the context of policy implementation and policy evaluation band 7 community learning disability nurses were expected to;

***‘...lead, initiate and audit the development of policies and strategies demonstrating highly developed influencing skills at all levels of primary and secondary healthcare, local authority, and voluntary organisations to ensure that people with learning disabilities are included within local and national targets for reducing health inequalities, NSFs, PCT local delivery plans and local commissioning structures’ (JD7YHFT), and,***



*‘**Contribute to the wider community health services health initiatives as required i.e. Essence of care, NSF implementation groups**’ (JD7TH).*

**7.3.7.7 Directed enhanced services (DES) (8%).** Band 7 community learning disability nurses were expected to be involved in the implementation of enhanced services in the implementation, and evaluation phases of the policy cycle. In the implementation phase the nurses were expected to;

*‘**...facilitate Directed Enhanced Services (DES) for Annual Health Checks for people with learning disabilities known to local authority**’ (JD7BD), and,*

*‘**Advise and support primary care in their implementation and evaluation of the local and Direct Enhanced Services for people with learning disabilities**’ (JD7SY).*

In the evaluation phase of the policy cycle the nurses’ expected public health roles involved;

*‘**Developing systems within primary care services that can be used to assess performance specific to meeting the health needs of people with learning disabilities - collection of data in relation to the enhanced service specifications...Supporting primary care services to deliver the outlined specifications of the enhanced services...To work in health centres and practices across C and H who have signed up to participate in the delivery of the Local Enhanced Service**’ (JD7H2).*

7.3.7.8 **Diabetes (8%).** Band 7 community learning disability nurses' expected involvement with the public health policy on diabetes was in implementation as in the following examples. The nurses were expected to;

*'Ensure 'achieving good health' for people with LD in line with national and local health improvement plan, targets i.e. reducing cardiac diseases; obesity and **diabetes** and smoking cessation etc.'*  
(JD7BD),

*'To liaise with specialists to improve access to health services for people with learning disabilities (epilepsy, **diabetes**, mental health specialists)'* (JD7H1), and,

*'To take the lead in the planning and development of shared care with primary and secondary health services i.e. nurse-led epilepsy clinic, **diabetes care**, audiology, sexual health and health promotion'*  
(JD7TH).

7.3.7.9 **Obesity (5%).** Band 7 community learning disability nurses' expected involvement with the policy on obesity was rather ambiguous in that it was not clear what their role in the implementation was. The following example illustrates this ambiguity;

*'Ensure 'achieving good health' for people with LD in line with national and local health improvement plan, targets i.e. reducing cardiac diseases; **obesity** and diabetes and smoking cessation etc.'*  
(JD7BD).

7.3.7.10 **Sexual health (5%).** Band 7 community learning disability nurses were expected to be involved in the implementation of sexual health initiatives through leadership, and influencing others. In the first context band 7 community learning disability nurses were expected to;

*‘...take the lead in the planning and development of shared care with primary and secondary health services i.e. nurse-led epilepsy clinic, diabetes care, audiology, **sexual health** and health promotion’ (JD7TH).*

In the second context band 7 community learning disability nurses were expected to;

*‘Influence the work with partners in community care planning including learning disability, **sexual health**,...to build the health improvement agenda into these arenas’ (JD7L).*

7.3.7.11 **Cardiac diseases (3%).** Although band 7 community learning disability nurses were expected to be involved in the implementation of the public health policy on cardiac diseases the example below is ambiguous as to what that role would be. The nurses were expected to;

*‘Ensure ‘achieving good health’ for people with LD in line with national and local health improvement plan, targets i.e. **reducing cardiac diseases**, obesity and diabetes and smoking cessation etc.’ (JD7BD).*

7.3.7.12 **Smoking cessation (3%).** As with cardiac diseases although band 7 community learning disability nurses were expected to be involved in the

implementation of the public health policy on cardiac the example below is ambiguous as to what that role would be. The nurses were expected to;

*‘Ensure ‘achieving good health’ for people with LD in line with national and local health improvement plan, targets i.e. reducing cardiac diseases; obesity and diabetes and **smoking cessation** etc.’ (JD7BD).*

7.3.7.13 **Equally well (3%)**. The expected involvement for band 7 community learning disability nurses was in the implementation phase of the policy process, as illustrated in the following example;

*‘The project would build on the recommendations reported in the Joint LLD Strategy and the Scottish Government’s “**Equally Well**” policy to address equitable access to healthcare for people with learning disabilities...This national approach, encapsulated by the Scottish Government publication in 2008, Equally Well, and the associated action plan, is reflected in Lothian’s commitment to **developing and implementing strategic programmes, which incorporate promotion, prevention, care and treatment elements**’ (JD7L).*

7.3.7.14 **Darzi (3%)**. The following example demonstrates that band 7 community learning disability nurses were expected to advise, and support other clinicians regarding the implementation of the relevant recommendations made in the Darzi report;

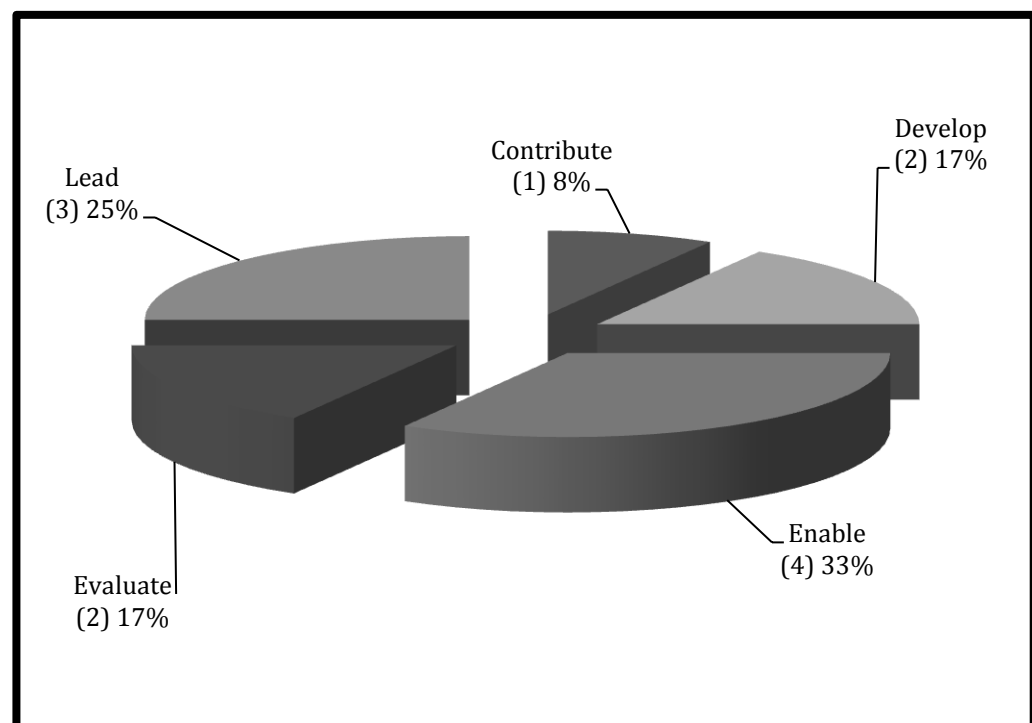
*‘**Advise and support the acute trust in the implementation of recommendations as outlined in national policy / guidance – ‘Healthcare for All’ and **Darzi review**, specifically related to learning disability**’ (JD7SY).*

### 7.3.8 **Band 8 nurses public health roles**

7.3.8.1 *Figure 7g* shows how band 8 community learning disability nurses were expected to fulfil their public health roles. Broadly, band 8 nurses' public health roles were expected within the decision-making, implementation, and evaluation phases of the policy cycle through providing leadership, enabling others, developing services, evaluating policy effectiveness and contributing to policy development. However, it is important to highlight the potential significance of the sample size of job descriptions for this band when interpreting these findings.

7.3.8.2 *Enable (33%)*. Broadly band 8 nurses were expected to enable others to implement relevant policies by ensuring evidence-based practice and supporting other professionals in their relevant roles. The nurses were

*Figure 7g:* Band 8 nurses' public health role expectations ( $n = 6$ ).



expected to;

*‘Lead on promoting and **enabling research based nursing practice to enable health improvement** for people with learning disabilities...Evolve and develop the roll of Consultant Nurse as highly specialist expert clinical practitioner, researcher and educator to **enable health improvement for people with learning disabilities...** Support nurses and others with highly complex **specialist patient care issues** where there are high risk factors involved including child protection and the protection of vulnerable adults...Develop and sustain communication networks...nationally and internationally with people with learning disabilities, their carers, the independent sector...to support the development of strategy and policy and the development and implementation of evidence based practice’ (JD8L),*

*‘...provide a **specialised advisory, support and liaison role regarding Children’s Learning Disability Services with a range of staff from health, social work, education and independent sector providers / services...**’ (JD8B), and,*

*‘...ensure support for delivering the wider health agenda of ‘Valuing People’ and ‘Valuing People Now’ including through the relevant PSA indicators and through Local Area Agreements’ (JD8NHSL).*

7.3.8.3 **Lead (25%).** Band 8 nurses were expected to provide leadership in the implementation of a number of public health policy initiatives in a variety of circumstances. In the first context band 8 nurses were expected to;

*'Lead on implementing delegated aspects of promoting health, supporting inclusion and...contribute to the NHSL health plan and Partnership-in-Practice agreements aimed at improving the lives and health of people with learning disabilities...'* (JD8L).

In the second context the nurses were expected to;

*'Lead on promoting and enabling research based nursing practice to enable health improvement for people with learning disabilities...'* (JD8L).

In the third context band 8 nurses were expected to;

*'...be an effective professional **lead** for the strategic health facilitator post and provide mentorship'* (JD8W),

and, in the fourth context the nurses were expected to;

*'Lead a team to oversee the development of a cohesive approach to challenging discrimination resulting in poor healthcare access for...and support the NHS commitment to equalities and access to healthcare for all...'* (JD8NHSL).

7.3.8.4 **Evaluate (17%).** Although no specific references were made regarding how band 8 nurses were expected to evaluate any specific policy initiatives, the following examples suggested that they were expected to have a significant role in evaluating the effectiveness of a wide range of policies. The nurses were expected to;

*'Identify, establish and **evaluate best practice approaches to health promotion, health education and health screening** for people with learning disabilities in partnership with specialist learning disability*

*health services, primary care services, people with learning disabilities and other key stakeholders' (JD8L), and,*

*'...develop information systems in the performance management of the key measures to identify progress against health service access in particular for people with a learning disability' (JD8NHSL).*

7.3.8.5 **Develop (17%).** Band 8 nurses were expected to have a 'development' role through developing strategies, research, and evidence-based practices. However, it is not clear how this role would contribute to the development of public health policy. On the other hand, it could be argued that research, and strategy development could contribute to policy development. The following example illustrate how band 8 were expected to;

*'Collaborate on the development of partnership working with statutory and independent sector agencies both locally and nationally to promote and **develop a strategic approach to health improvement** for people with learning disabilities in line with clinical governance arrangements...**develop and improve healthcare** for people with learning disabilities...**Develop and contribute to national and international networks aimed at improving the lives and health** of people with learning disabilities...**Evolve and develop the role of consultant nurse as highly specialist expert clinical practitioner, researcher and educator to enable health improvement** for people with learning disabilities...**establish best practice approaches to health promotion, health education and health screening** for*



*people with learning disabilities in partnership with specialist learning disability health services, primary care services, people with learning disabilities and other key stakeholders.....Initiate and establish collaborations nationally and internationally to promote research activity to improve healthcare for people with learning disabilities'* (JD8L).

7.3.8.6 **Contribute (8%).** Band 8 nurses were expected to make significant contributions to initiatives that would contribute to the improvement of health, and health outcomes for people with learning disabilities at local, national, and international levels. The following example illustrates these expectations;

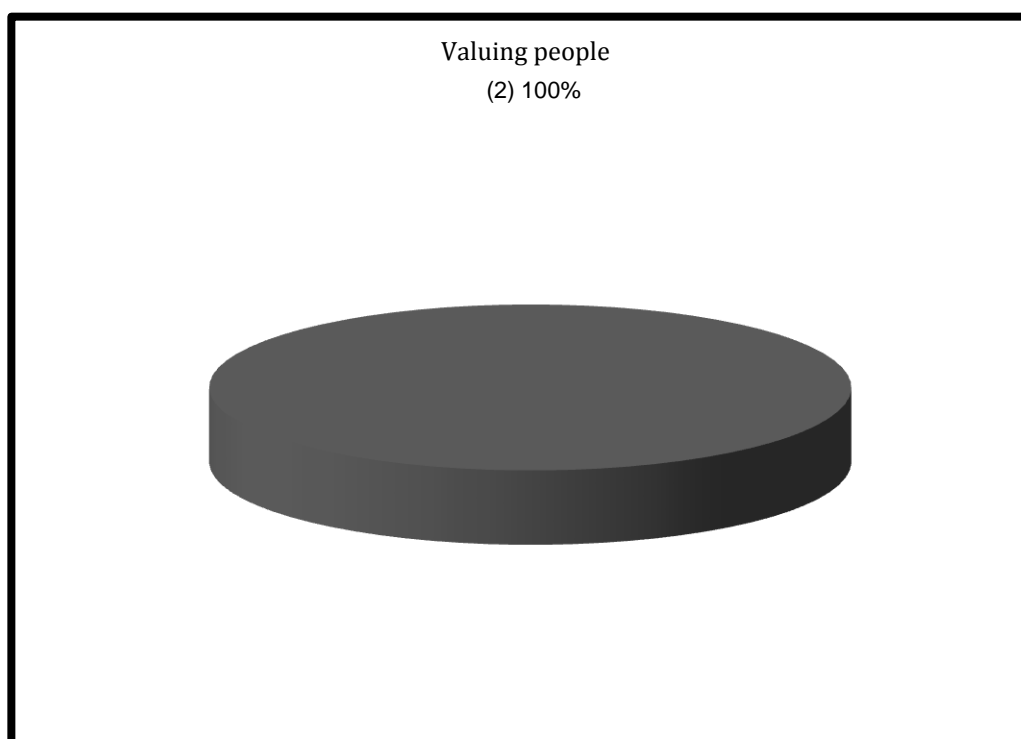
*'Lead on implementing delegated aspects of promoting health, supporting inclusion and the learning disability health needs assessment; contribute to the NHSL health plan and Partnership-in-Practice agreements aimed at improving the lives and health of people with learning disabilities...contribute to national and international networks aimed at improving the lives and health of people with learning disabilities'* (JD8L).

### **7.3.9 Band 8 nurses policy involvement**

7.3.9.1 *Figure 7h* illustrates relevant policies or policy areas band 8 nurses were expected to be involved in as per the job descriptions and person specifications. Predominantly band 8 learning disability nurses' involvement with the public health policy process was in the implementation, evaluation, and decision-making phases of the policy

process. However these findings need to be interpreted with caution given the size of the sample.

Figure 7h: Band 8 job description policy references ( $n = 6$ ).



- 7.3.9.2 ***Valuing people (100%).*** The expected involvement with *Valuing people* (DH 2001), and *Valuing people now* (DH 2009b) was in the implementation phase of the policy process. The nurses were expected to;
- ‘Lead a team to oversee the development of a cohesive approach to challenging discrimination resulting in poor healthcare access...lead on the implementation of the nation learning disabilities strategy ‘Valuing People Now’ and support the NHS commitment equalities and access to healthcare for all...ensure support for delivering the wider health agenda of ‘Valuing People’ and ‘Valuing people now’ including through the relevant PSA indicators and through local area agreements’ (JD8NHSL).***

## **7.4 Data analysis stage 4 – Initial codes**

7.4.1 In the fourth stage of the data analysis process I collapsed the initial free nodes (role descriptors), and policies and policy references into initial codes (role and policy) (see *Table 7c*).

Table 7c: Exploratory phase initial codes (public health roles and policy references).

NHS band	Role codes	<i>A priori</i> categories	Policy codes
<b>5</b> <b>(n = 63)</b>	Implement / Reduce inequalities / Facilitate / Liaise / Contribute / Promote / Develop / Plan	Health education  Health surveillance  Health prevention  Health protection  Health promotion	Valuing people / Health action planning / Health facilitation / Healthy lifestyles / National services frameworks
<b>6</b> <b>(n = 87)</b>	Reduce inequalities / Facilitate / Advise / Enable / Develop / Enable / Promote / Implement / Contribute		Obesity / National service frameworks / DES / Health facilitation / Health action planning / Diabetes / Health screening / QOF / Valuing people
<b>7</b> <b>(n = 45)</b>	Implement / Lead / Facilitate / Promote / Liaise / Reduce inequalities / Enable		Health action planning / Health facilitation / Health screening / Healthcare for All / Equally Well / Diabetes / National service frameworks / Valuing people / Cardiac diseases / Obesity / Smoking cessation / Sexual health / Darzi / DES
<b>8+</b> <b>(n = 6)</b>	Lead / Develop / Contribute / Enable / Evaluate		Valuing people

## 7.5 Data analysis stage 5 – Initial themes

7.5.1 The fifth stage in the data analysis process involved two separate, and consecutive analyses. In the first phase of the analysis I collapsed the codes into theoretical and axial codes (see *Table 7d*). In the second phase of analysis stage 5 I collapsed the axial codes into initial themes (see *Table 7d*).

*Table 7d: Exploratory phase axial codes and initial themes.*

NHS band	Axial codes	<i>A priori</i> categories	Initial themes
<b>5</b> ( <i>n</i> = 63)	Facilitating Contributing Implementing Promoting	Health education  Health surveillance  Health prevention  Health protection  Health promotion	Direct policy implementation Supporting others to implement policy Develop practice
<b>6</b> ( <i>n</i> = 87)	Educating Enabling Facilitating Implementing Promoting		Direct policy implementation Supporting others to implement policy Develop practice Policy dissemination Facilitate policy implementation
<b>7</b> ( <i>n</i> = 45)	Implementing Leading Educating Facilitating Promoting Supporting Evaluating		Direct policy implementation Supporting others to implement policy Develop practice Policy dissemination Policy evaluation Facilitate policy implementation
<b>8+</b> ( <i>n</i> = 6)	Leading Collaborating Developing Enabling Evaluating		Direct policy implementation Leading others to implement policy Contribute to policy development Policy dissemination Policy evaluation

## 7.6 Data analysis stage 6 – Themes

7.6.1 In the sixth stage of the data analysis process I collapsed the initial themes into theoretical *in vivo* themes (see *Table 7e*).

*Table 7e:* Exploratory phase public health policy implementation themes

NHS band	<i>A priori</i> categories	Initial themes	Theme (roles)
5 ( <i>n</i> = 63)	Health education	Direct policy implementation Supporting others to implement policy Develop practice	Policy implementation
6 ( <i>n</i> = 87)	Health surveillance  Health prevention	Direct policy implementation Supporting others to implement policy Develop practice Policy dissemination Facilitate policy implementation	Policy implementation Policy evaluation
7 ( <i>n</i> = 45)	Health protection  Health promotion	Direct policy implementation Supporting others to implement policy Develop practice Policy dissemination Policy evaluation Facilitate policy implementation	Policy implementation Policy evaluation
8+ ( <i>n</i> = 6)		Direct policy implementation Lead others to implement policy Contribute to policy development Policy dissemination Policy evaluation	Policy implementation Policy evaluation Policy making

## 7.7 Data analysis stage 7 – Densified themes (roles and policies)

7.7.1 In the seventh stage of the data analysis process I collapsed the policy codes identified in data analysis stage 4 (see *Table 7c*) in two stages into theoretical and *in vivo* policy themes (see *Table 7f*). These were then tabled together with policy implementation role themes identified in data analysis stage 6 (see *Table 7e*).

Table 7f: Exploratory phase themes (policy and policy implementation roles)

Densified themes (policy)	Policy codes	<i>A Priori</i> categories	Densified themes (roles)
Learning disability health access	DES Health action planning Health facilitation QOF Valuing people	Health education  Health surveillance	Policy implementation
Public health strategies	Diabetes Obesity Reduce cardiac diseases NSFs Sexual health Smoking cessation	Health prevention  Health protection  Health promotion	Policy evaluation
Policy evaluation and re-design	Darzi Healthcare for All		Decision making
Public health policy	Equally Well Healthy Lifestyles		

## 7.8 Summary of findings

7.8.1 There was limited consistency in how public health policy was reflected in community learning disability nurses' job descriptions across NHS bands.

7.8.2 The findings presented here demonstrated that there were differences in role expectations organisationally in community learning disability nurses' involvement with public health policy.

7.8.3 The expected public health roles for community learning disability nurses could be categorised as **health education, health promotion, healthcare access, health protection, and health surveillance.**

7.8.4 There were four core policy themes in which community learning disability nurses were expected to enact the public health roles (1. **learning disability health access**, 2. **public health strategies**, 3. **policy evaluation and re-design**, and 4. **'public' health policy**).

7.8.5 The findings presented here show that community learning disability nurses were expected to be involved in the public health process in the **implementation phase**, **evaluation phase**, and **decision-making phase** of the policy cycle. This involvement was however dependent on the NHS band of incumbents. Band 5 community learning disability nurses were expected to be involved in public health **policy implementation**. Band 6 and band 7 community learning disability nurses were expected to be involved in public health **policy implementation, and policy evaluation**. Band 8 nurses were expected to be involved in the **policy implementation, policy evaluation** and **decision-making phases** of the policy cycle. However, there was lack of clarity as to how these roles would be carried out.

## **7.9 Conclusion and key finding**

7.9.1 In this study, the job descriptions and person specifications analysed did not adequately and consistently articulate the public health policies community learning disability nurses were expected to implement for people with learning disabilities. There was also significant ambiguity and inconsistencies in how community learning disability nurses were expected to enact their public health roles in implementing public health policies, and public health initiatives for people with learning disabilities.



7.9.2 In the presence of the ambiguities identified above further research was essential in order to;

1. describe how public health policies are translated into community learning disability nurses' roles in the practice setting;
2. investigate how community learning disability nurses understood, and enacted their public health roles in the practice setting;
3. identify and describe the moderators of how policy is translated into community learning disability nurses' public health roles; and,
4. formulate a hypothesis on how community learning disability nurses enact their public health roles.

In the following chapter I report on the findings from stage 2 of the study in which I sought to address these issues.

***Key finding***

**There was limited consistency in how public health policy was reflected in community learning disability nurses' job descriptions across bands and organisationally.**

## **Chapter 8: Results 2 – Semi-structured interviews (descriptive phase)**

### **Introduction**

In this chapter I present the findings and my conclusions from stage 2 of the study. In chapter 7 I explained the challenges even a seasoned qualitative researcher faces when presenting qualitative results due to the absence of a universal protocol for reporting findings (Knafl and Howard 1984; Glaser and Strauss 1966). The rationale for my approach to the presentation of results was the same as for stage 1, and hence no further explanation is given here.

In this stage, as in stage 1, I adopted a theory and methodology guided approach, complimented with a logical presentation of narratives and themes as compared to the organisation of codes in order of perceived importance used in stage 1 (Chenail 1995).

In chapter 5 I detailed my approach and rationale to grounded theory data analysis, and gave an overview of the webbed nature of the process. In total the data analysis process went through 8 cyclical, non-linear and repeated stages before conclusions could be made. These stages are clearly outlined throughout this chapter.

### **8.1 Data analysis stage 1 – Open coding (1)**

8.1.1 The process of open-coding generated large volumes of data, and these are presented in *Appendix 8a*. The open codes were later mapped to the initial themes that emerged during data analysis stage 5 (see *Appendix 8a*).

## 8.2 Data analysis stage 2 – Code clusters

8.2.1 In this stage of the data analysis process I organised the *in vivo* open codes into a table (see *Appendix 8b*). I then extracted the open codes, and organised them into clusters, which reflected their origins in the data (see *Appendix 8b*).

## 8.3 Analysis Stage 3 – Referenced ‘line-by-line’ data extracts

8.3.1 There were predominantly two outputs from data analysis stage 3. The first outputs were *in vivo* line-by-line extracts illustrating key data sources for the categories and themes. In the second output I diagrammed all the coding families that emerged from the data.

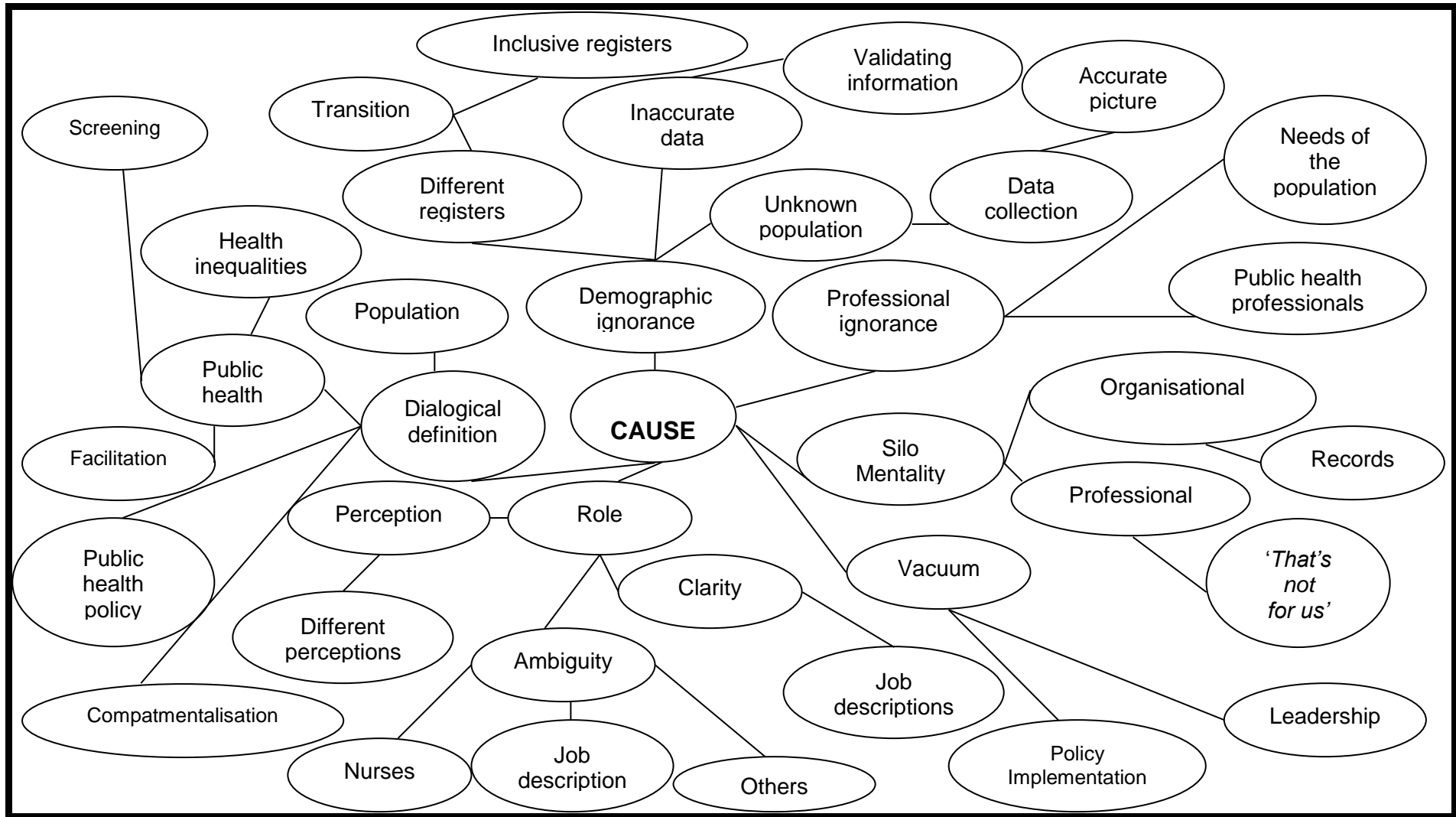
### ***Cause families of public health role moderators***

*Figure 8a* illustrates the underlying ‘cause’ code families that influenced how community learning disability nurses enacted their public health roles.

8.3.2 ***Dialogical definition.*** The examples given illustrate that lack of an agreed definition of the meaning of what public health entails had a significant influence on how community learning disability nurses enacted their public health roles;

*‘I also think that **public health to me**, and this is not saying that anybody else is wrong, **means something different**, so to me public health is not just health facilitation or public health screening but I think to a lot of learning disability nurses it is’ (P11N17);*

Figure 8a: Cause families of public health role moderators.



*'I think when you say public health policy, public health affects the entire population and I think you see the word "public health policy" and learning disability staff thinks it's not for them and public health staff think that doesn't include learning disabilities because learning disability services think about that. So I think **"public health policy" in itself, the words are problematic for people**, I think in learning disabilities the ownership always sits somewhere else and **I think in a way it's a problem about compartmentalising various different things**' (P9BCC5);*

*'The other thing that is very important in the context of this is that we are clear in **what we mean by public health...**' (P10NHSCWP7); and,*

*'First of all I think **there is a lack of clarity about what public health means** and public health does mean something different to addressing health inequalities, it is more than that, when I'm reading anything about improving healthcare and learning disability I'm reading about improving access to primary healthcare, I'm reading about health facilities, I'm reading about health screening, I'm reading about acute care liaison and of course that is part of public health. But to me public health needs to be considered as merely the science of public health and that is about needs assessment, so when you are working with a group of learning disability nurses or as any profession because **I think public health goes beyond nursing**, we should be doing things like needs assessments like health visitors have a core function to needs assess the population, I think learning disability nurses should be*

*required to do the same so I think there's that lack of understanding'*  
(P11N17).

8.3.3 **Demographic ignorance.** The second cause coding family shows that there was a lack of demographic intelligence about the size of the population of people with learning disabilities in the UK as in the following examples;

*'I've now got some lists of people and I'm trying to check them against our registers because we don't want them doing health checks on people we don't know and they we're saying, well hang on a minute, **these registers are different to ours**, so there's work that needs to be done on that and again is another one of my targets to do that this year'* (P5NHSH7);

*'One of the things we are going to look at as we roll out the health check program as well is also the accuracy of that information, **there are some concerns that some of the people that were identified through GPs as having learning disabilities don't actually have them**, so we are looking to do some validating of information of the GP registers as well'* (P7NHSH56);

*'**What we don't know is, the next big challenge is the kids coming through.** If we can make any change, actually in the UK, it is to change the QOF, for the QOF registers to include children. We have just asked NICE to ask for submissions for changes to the QOF. I think **what we need is a register from cradle to grave**, for GPs to start identifying children that are coming through'* (P8NHSG5);

*'There's a fourth area of public health priority for us and it is linked to **not knowing the populations**, we've got everybody tagged as much as we can but we're not getting the data and that's because people aren't asking the right questions. Public health departments and public health analysts don't ask questions around specific populations like that, they ask around cardiovascular disease or they ask what the health in a deprived area is for example, they work on educating them to start asking very different questions, so I think there's a very big piece of priority work around that...It's aimed at a level that people with learning disabilities wouldn't understand and couldn't link into very easily and they're very reluctant to alter things to work for specific minority groups, so **for me the limitations are about not understanding our population** and how they can work with them because there is ways around it'...I think that's been very useful but it was quite insightful yesterday, that **we had people on the learning disability register that the GP didn't know were registered with his practice and he brought 5 patients that we had never heard of that he thought we were involved with but we didn't have any data on them**' (P10NHSCWP7);*

*'Our data collection depends on those known to services and that's another really important thing because **the majority of people with learning disabilities are not known to services**, those people will tend to be in the minor category of learning disabilities...so we need to think about how to collect data, how to understand people and we also need to start really doing robust needs assessments, starting with*

*health visitor colleagues in relation to the work that they do around needs assessment'* (MDNI17); and,

*'So we've got all that **I think what we need to do not at a local level is pin that down and drill down so we get a more accurate picture of what the local situation is**...So if you've got a significant number of people, like we've got 650 people on our register but we estimate with a preference rate that really we should be nearer 3500 to 4000 people. **We are only seeing a small cohort of the known population**, so we know people with learning disabilities are out there and again given with the ethnicity background we have talked about, we would expect high numbers of people of Southern-Asian communities with learning disabilities to be at home with their families. Anyway so there are people out there that we don't know about'* (P14NHS3).

- 8.3.4 **Role perception.** Although there was only one referenced source for this cause, it has relevance and significance. This shows that the public health role of community learning disability nurses was viewed differently by the nurses themselves, other professionals, and by people with learning disabilities;

*'People see the role in different ways'* (P1DH1).

- 8.3.5 **Role ambiguity.** The following examples illustrate the significance and extent of role ambiguity of the public health role of community learning disability nurses;



*'I think the limitations are where **we shouldn't be doing other people's jobs**, so for me its about making sure that we are doing what the learning disability nurse should be doing in terms with committing public health policy and not doing the job that perhaps the GP should be doing or what the community or district nurse should be doing or what the social worker should be doing or whoever else, **we shouldn't be doing their jobs** so **we need to be clear about the boundaries of our own roles** so for me that's the limitation, of being really clear about is this a nursing role or isn't it...**When we were in hospitals we knew what we did. We actually did a lot of social care work and when we went into the community some of us transferred that into the community**, but its not the same job because we are in social care and you no longer need to do everything. **So historically we brought that into the community, being all man to everyone**. I think we are our worst enemies in terms of role clarity. If we came out and said, for example some specialist nurses, it is really clear what they do, but we came out and said I can do that and that. We picked up a whole load of stuff and I think we are victims of our own abilities because of the breath of our knowledge. **I know I do things I shouldn't do because there is really no one else to do it'** (P5NHS7); and,*

*'I think as well it hasn't been focused on enough within job descriptions **I don't personally think that managers as they set up learning disability services they give enough thought to the importance of job descriptions and how important they can be in dictating the services'** (MDNI17).*

8.3.6 **Role clarity.** Clearly defining the public health roles of community learning disability nurses appears to have a positive influence on how they enact their public health roles as illustrated here;

*'In my role it is very clearly defined, my job description tells me I have a strategic responsibility to ensure that the health needs of people with learning disabilities are addressed to reduce the health inequality agenda. It tells me that I need to work closely with the public health department here and look at strategies, it tells me that I need to develop a strategy in conjunction with public health looking at the health of people with learning disabilities. So those are the main points for me in the job description' (P6NHSG5).*

8.3.7 **Professional ignorance.** The following example illustrates that a lack of sensitisation in generic public health practice regarding the complexity of the health and public healthcare needs of people with learning disabilities impacted on how community learning disability nurses enacted their public health roles;

*'My biggest challenge in G... is working with public health consultants. I think that is because of the inability to see people with learning disabilities as anything other than a chronic disease. The public health consultants view LD not as a condition, because they are used to working with big chronic diseases in the population. They can't make that intellectual shift to say that it's not a condition and not a disease and that the condition will result in people having a number of diseases' (P8NHSG5).*

8.3.8 **Organisational silo mentality.** The examples given below illustrate that organisational boundaries appeared to de-sensitise organisations to the health and public health needs of people with learning disabilities. This de-desensitisation in turn appeared to contribute to the difficulties community learning disability may have in enacting their public health roles;

*‘The other limitation I think is the problem with the health policy stuff is that **not everybody sees it as their business** and it’s everybody’s business, especially the councils and agencies...and even in community teams, in my own organisation on the health side, it is still rows about, “**but that’s not for us to do**”, **but we’ve all got a responsibility to do it**’* (P10NHSCWP7); and,

*‘You’re not always privy **even as a senior clinician, you’re not always privy to some of the developments** that are going on’* (P14NHSH3).

8.3.9 **Professional silo mentality.** This example illustrates the significance, and the negative influences professional boundaries could have had on how community learning nurses enacted their public health roles;

*‘The same issues about how do we know who these people are and if they’re entitled to health action plans if they’re not known to services, we found that quite difficult, **we tried to work with GPs looking at their registers but that didn’t always work out**’* (P16NH SB1).

8.3.10 **Policy implementation vacuum.** Lack of strategies on how public health policies and initiatives are implemented for people with learning disabilities appeared to have significance on how community learning disability enacted their public health roles, for example;

*'In NI we have only in the last year set up an implementation group to implement it, five years later but the principles behind Equal Lives in the intervening years have influenced all of our practice, so **the document was launched in 2005 but there was no real implementation process put in place**' (P10NHSCWP7).*

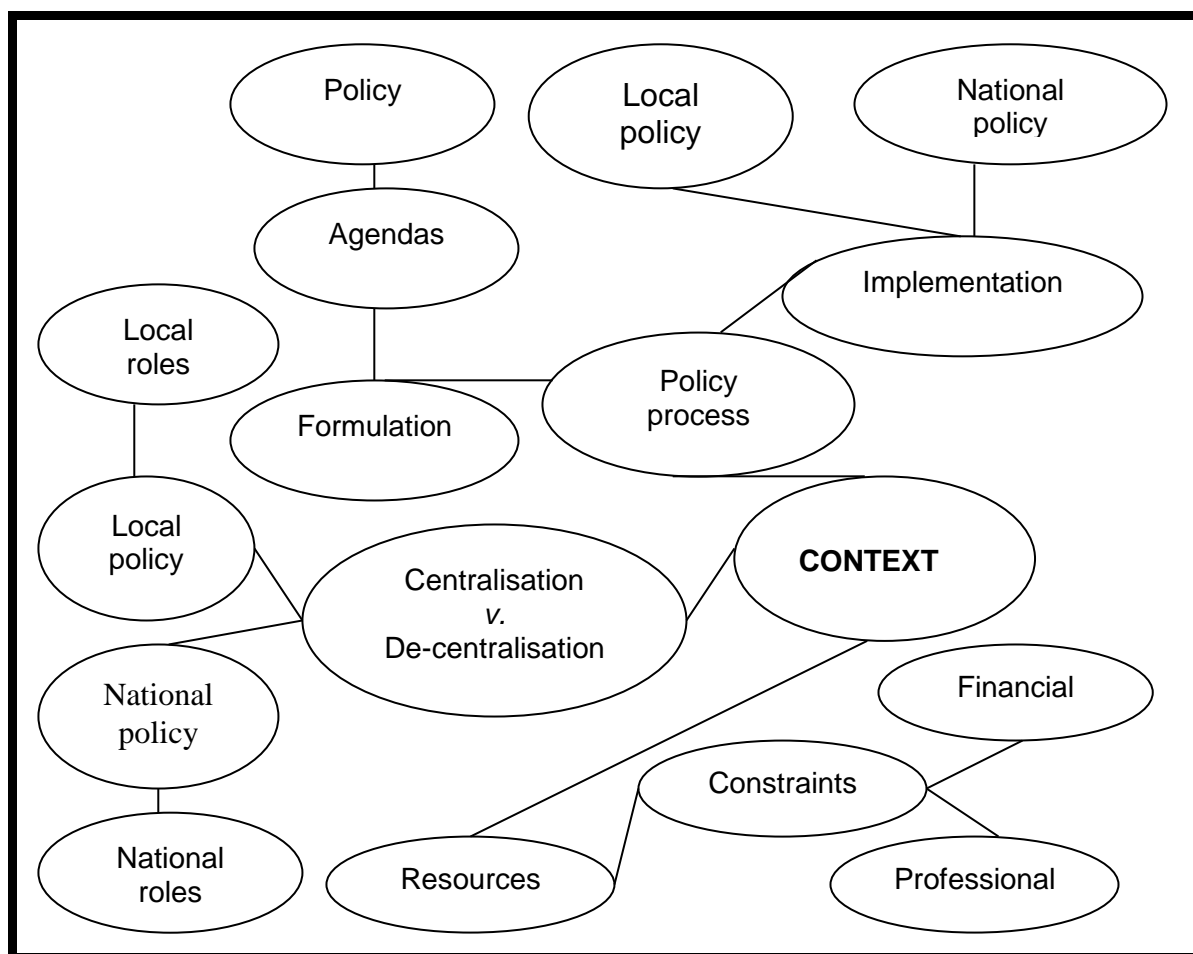
8.3.11 **Leadership vacuum.** The example below suggests that there was a leadership vacuum in learning disability practice that was likely to negatively impact on how community learning disability nurses enact their public health roles;

*'Representation **at the top level** for people with learning disabilities, **are they fully represented by people who are keen and have a real interest in learning disabilities?**' (P13NHSL2).*

### **Context families of public health role moderators**

Figure 8b illustrates the 'context' code families. There are three families (centralisation versus de-centralisation, policy process, resources), which demonstrate moderators of how community learning disability nurses enacted their public health roles.

Figure 8b: Context families of public health role moderators.



8.3.12 **Centralisation versus decentralisation.** The example here illustrates the significance and impact of the divide between central government, and local public health policies and initiatives on how community learning disability nurses enacted their public health roles;

*‘I had a phone call from Tony Blair’s office when he was Prime Minister asking us to supply a nurse to go and meet him and then we got another phone call to say **in that person’s job description, ‘what are they doing in relation to national policy around health?’** So ever since then it taught me lessons that we have national policy and then we have local policy and **how does my job fit into that national policy so it hasn’t always been quite clear about national policy***

*around health and how we break that down into local roles'*  
(P16NHSB1).

8.3.13 **Policy formulation and implementation.** How community learning disability nurses were involved in the whole public health policy cycle appeared to have an influence on how they in turn enacted their public health roles, for example;

*'So I think it is about being proactive really and keeping that so if like you're **shaping the agendas and the policy**'* (P16NHSB1); and,

*So it's about both really, **it's about devising policy, but also to make sure that practice meets policy, that sort of thing**'* (P17NHSNH3).

8.3.14 **Resource constrains.** The example given below illustrates the significance of resource constraints on how community learning disability nurses enacted their public health roles in their work with people with learning disabilities.;

*'Whereas the policy document says there should be 12 health facilitators in NI, there wasn't the money for that, so what we did was we looked at our community learning disability nursing profession and in my Trust we only had community nurses. We didn't have a hospital. All of our learning disability nurses were community based. We had a radical look at the work we all did, and we came up with, I suppose our local policy around health facilitation'*  
(P10NHSCWP7).

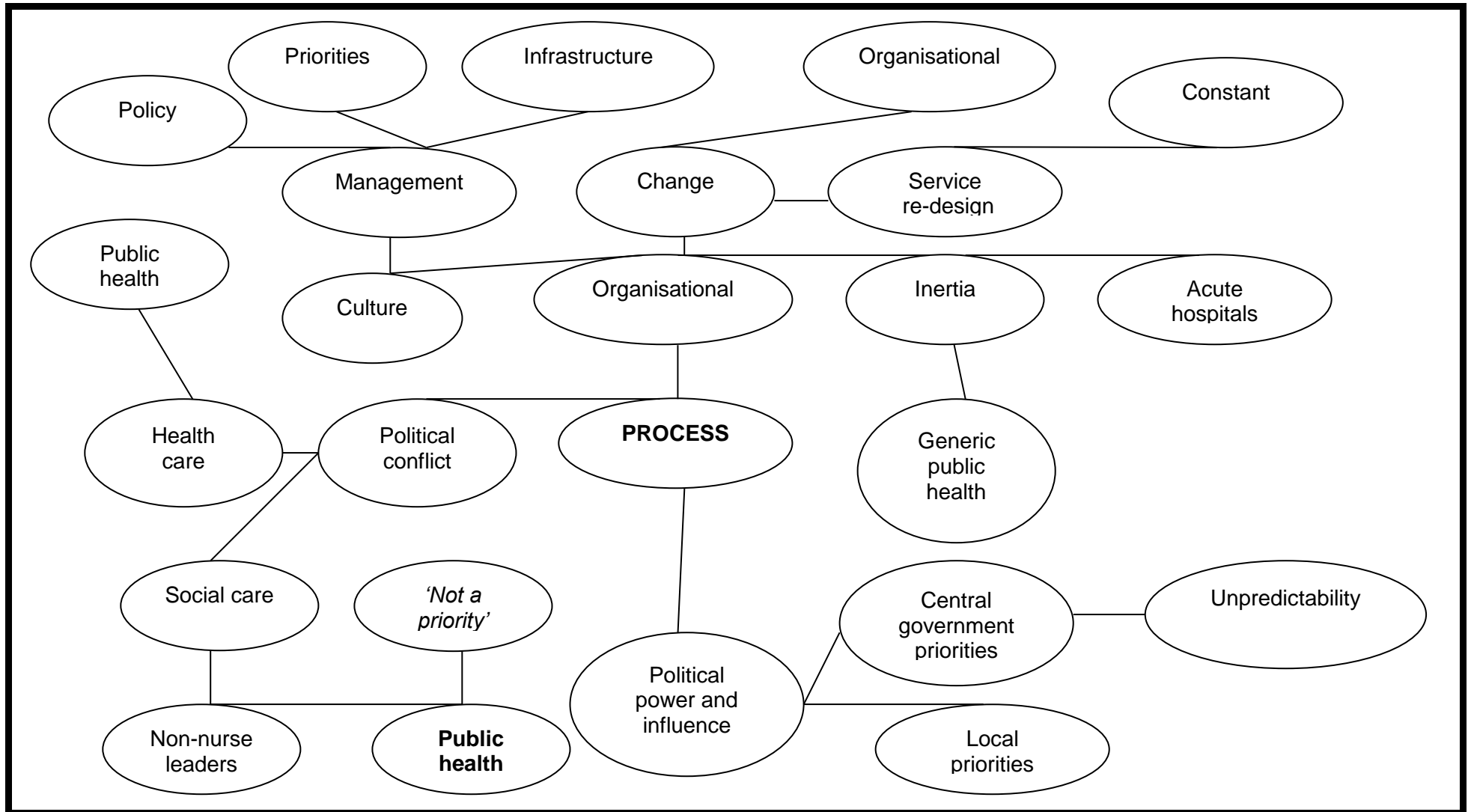
### ***Process families of public health role moderators***

*Figure 8c* illustrates the 'process' code families. There are three families (organisation, political power and influence, political conflict), which demonstrate moderators of how community learning disability nurses enacted their public health roles.

8.3.15 ***Political power and influence.*** The example below demonstrates the importance of the influence of political power and political influence on how community learning disability nurses enacted their public health roles;

***'So it's the government that dictates what I do really, so like yesterday I was speaking at a conference, which is fine, but at a stroke I could say I have to drop all that to do something else. It is unpredictable and quite challenging'*** (P1DH1).

Figure 8c: Process families of public health role moderators.





8.3.16 **Policy conflict.** How community learning disability nurses who participated in this stage of the study enacted their public health roles may have been influenced by political priorities, which may conflict with the public health needs of people with learning disabilities as illustrated in this example;

*'We work within a health and social care context, so up the line our manager is also a non-nurse and there is a perception that public health work, prevention work is not supposed to be targeting those in the greatest need, it's about preventing things, yes but let's stay with the severe challenging behaviour, let's stay with the real complex problems in relation to people moving in and out of hospital, to consider setting up a group of 8-10 people to try and **help them promote their own health, it was not seen as a priority**' (P11N17).*

8.3.17 **Organisational culture.** The examples given below suggest that how health services are organised in the UK may have impacted on how community learning disability nurses enacted their public health roles;

*'It's not just about me and my job, **it's about how the whole policy and infrastructure is organised** and how we're running the work within those work streams' (P4NHSCL8); and,*

*'For learning disabilities I would say that **its about the management of the boards, we call them NHS boards, understanding and having a desire to look at the needs of people with learning disabilities** as I don't think that's there, because there are so many*

*priorities within the NHS so that's a barrier towards any progression'*  
(P6NHSG5).

8.3.18 **Organisational change.** The illustrations below demonstrate the significance of how organisational changes could have negatively impacted on how community learning disability nurses enacted their public health roles;

*'I think probably **the other thing that inhibits our ability is the organisational changes***' (P4NHSC8).

*'I think there were issues within the service requiring an attention at the time around service redesign, we were closing long stay hospitals, there was a need to develop more specialist nursing roles around particular areas, with the challenges and behaviours included in my job description and **I think those type of things have tended to dominate within the job description without being specific about the actual health promotion role, that's within LD Nursing***' (P7NHSH6); and,

*'It was reviewed in 2006 and the main reason for that review was **because of the merging of health boards** so my job extended geographically and **my job description was reviewed because of changes to the geographical boundaries***' (P8NHSG5).

8.3.19 **Organisational inertia.** The example below shows that how health service organisations responded to policy drivers was likely to influence how community learning disability nurses enacted their public health roles;

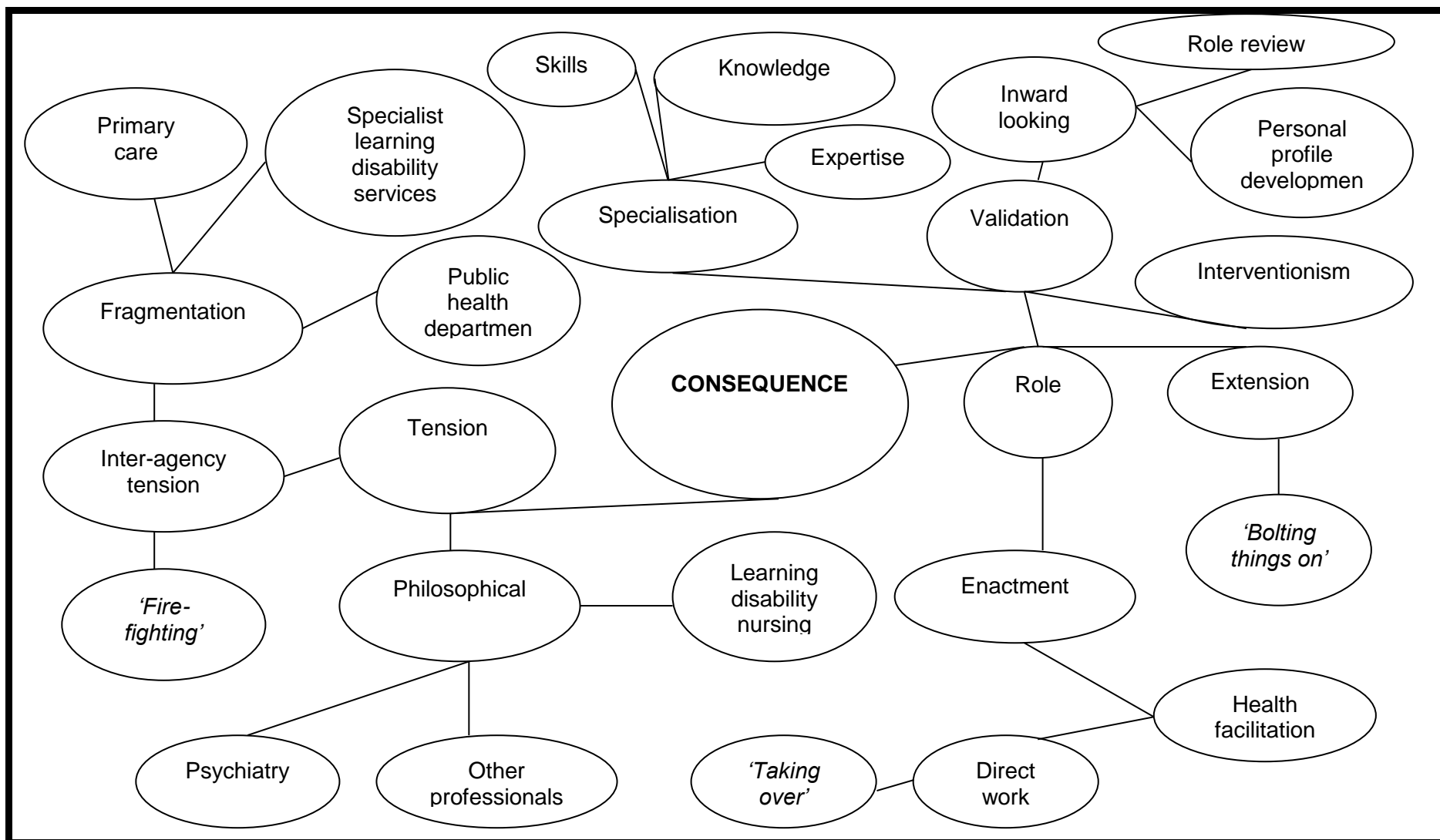
*'It was worrying for example, it talked about only 40% of acute hospitals are actually making some positive in-roads into the learning disability agenda and given that the Six Lives report was primarily focused on the acute sector, it's still slightly concerning that 18 months on, **only 40% of acute hospitals are dealing with the issues**' (P14NHSH3).*

### **Consequence families of public health role moderators**

*Figure 8d* illustrates the 'consequence' code families. There are two families (role, tension), which demonstrate moderators of how community learning disability nurses enacted their public health roles.

8.3.20 ***Inter-agency and philosophical tensions.*** The multi-disciplinary approach to the public health policy process may have resulted in inter-agency and philosophical tensions that impacted on how community learning disability nurses enacted their public health roles. The following statements illustrate this point;

Figure 8d: Consequence families of public health role moderators.



*'I think people were fire fighting and there was a very strong social services lead in the team who was fairly powerful and the same in the two other services and so to try and modernise the service and try to bring the service up to date. And try to work with our colleagues outside of the learning disability service. Its been a higher priority really, but public health is to say mine, and the one priority now, to actually get in with the new public health person and have some sort of joint strategy' (P5NHS7);*

*'There's also an issue about how learning disability services have historically sat under the offices of psychiatry of learning disability and doctors and the power that goes along with that are interested in mental health and psychiatry and yet many of the health needs fall out with the domain of psychiatry' (P10NHSCWP7);*

*'The major limitation at the moment is around how we are fragmented in terms of approach, we have well developed public health departments, we have primary care, which also has a role in the public health agenda and yet at the minute we are all working in quite separate silos and that is something else we are looking in to see how we can start bridging those gaps between us all and come up with some common agendas' (P7NHS6); and,*

*'So I think the interface between general health services and special health services are going to be absolutely critical in the future because it's not an either or' (P10NHSCWP7).*

8.3.21 **Role validation.** The following examples illustrate that community learning disability nurses who participated in this study may have engaged in public health activities that were intended to validate their wider 'nursing' roles;

***'Specialisation and interventionism is seen as justification of the LD nurse role'*** (P3NHS2G5);

***'People have become too inward looking'*** (P1DH1);

***'Some of the limitations come within learning disability services themselves, you have people within those services with a range of knowledge, skills and expertise and sometimes people like doing what they like doing because they like doing it and it might not actually be what we need them to do'*** (P10NHSCWP7);

***'Probably not in relation to learning disabilities, if it was a general public health review, then it would be up to me to go back to my manager and say. I think in the response to a new white paper that has come out, maybe I should review how my role might fit within this new white paper'*** (P9BCC5); and,

***'And then it was for me to develop my job profile and what I did around that but no it wouldn't have been laid out very clearly that a core aspect of my job was to develop the public health approach to people with learning disabilities but that was the first post and I think if we were doing it again we would be a bit more definitive about the expectation in relation to that'*** (P10NHSCWP7).

8.3.22 **Role extension.** Community learning disability nurses may have had their wider roles extended, which may have impacted on how they enacted their public health roles as illustrated in this example;

*'The Trust has also bolted onto my day-to-day job because before I was just in the learning disabilities division doing this work for the LD population but the Trust then needed to have somebody to take a lead for the whole organisation of public health, so medical director has got the overall umbrella lead and then I've got organisational, operational leadership. We've developed mental health facilitators for the mental health population and they've now come under my umbrella so **they bolt things on as you go into your job plan. So** when you re-look at your job description it doesn't marry up...So it was about reform and modernisation, sitting down and reviewing our roles, dropping off what we should drop off and start really giving a focus to what we should be doing in relation to health' (P10NHSCWP7).*

8.3.23 **Role encroachment.** The example below illustrates that community learning disability in the process of enacting their public health roles may have encroached on other professionals' public health roles;

*'With health facilitation, **sometimes as learning disability nurses or specialist learning disability professionals we feel confident about working with people with learning disabilities that we either take over or we don't help other people to feel comfortable'** (P17NHSNH3).*

## **8.4 Data analysis stage 4: Open codes (2)**

8.4.1 In this stage of the data analysis process, I further open coded the data with a primary focus on identifying public health role descriptors (see *Table 8a*). During the same process the codes were linked to conceptual and *in vivo* public health role categories (see *Table 8a*). In addition, during this phase terms relevant to public health policies and strategies were extracted (see *Table 8a*).



*Table 8a:* Descriptive phase data analysis stage 4 (open codes)

Public health role categories	Open codes (2) (roles)	Policy area / Context
Academic	Educate / Research / Lead	Agenda for change
Healthcare access	Facilitate / Reduce admissions / Reduce inequalities / Improve / Liaise / Support / Enable	DES Equally well Same as you SESP
Healthcare delivery	Direct patient care / Immunise	Smoking cessation
Health education	Educate on health inequalities / Lead	Obesity Investing for health
Health prevention and protection	Prevent ill-health	Health challenge Wales Healthcare for all
Health promotion	Promote / Lead / Implement	All Wales Initiative
Health surveillance	Collect data / Assess and analyse health needs	QOF Valuing people Diabetes
Leadership	Clinically mentor / Communicate / Organize / Supervise / Lead	Sexual health Six lives
Policy implementation	Develop / Implement / Disseminate / Advise / Communicate / Consult / Improve / Influence / Inform / Interpret	LES Equal lives Keep well programme Health needs assessments

## 8.5 Data analysis stage 5: Axial codes

8.5.1 *Table 8b* illustrates how open codes (1) (moderators) from data analysis stage 1 were reduced to axial codes. The axial codes were further analysed and collapsed into initial *a posteriori* categories.

*Table 8b: Descriptive phase data analysis stage 5 (axial codes).*

<b>Open codes (1) (moderators)</b>	<b>Axial codes</b>	<b>Initial a posteriori categories</b>
National policy / Local policy	Policy differences	Centralisation v. decentralisation
Unknown population / Transient population	Ignorance	Demographic ignorance
Collecting population data / Maintaining population data	Records	
What public health policy means / What public health means	Meaning	Dialogical definition
Professional interpretation	Dialogical interpretation	
Inter-professional working / Identity	Professional differences	Inter-agency and professional tensions
Compartmentalisation / Organisational differences / Multi-agency working	Service fragmentation	
Leadership / Representation / Knowledge	Lack of professional leadership	Leadership
Service redesign / Community care	Organisational change	Organisational change
Organisational role changes / Consolidation of roles / Specialist roles	Changing roles	
Response to adverse events	Organisational culture	Organisational immune response
Acute hospital response to policy		Organisational inertia
Responsibility for policy	Organisational responsibility	Organisational silo mentality
Cinderella service	Invisibility	
Lead agency / Priorities	Policy prioritisation	Policy conflict
Practice context / Health v. social care	Service organisation	
Implementation process / Delays in implementation	Policy implementation	Policy formulation and implementation vacuum
Devising policy / Being pro-active	Policy formulation	
Policy drivers / Government	Politics	Political power and influence
Decision making	Decision making	
Multi-disciplinary practice / Professional differences	Multi-professionalism	Professional silo mentality
Limited finance / Reduced capacity	Resources	Resource constraints
GP roles / Community LD nursing roles / Social work roles	Professional roles	Role ambiguity / Role clarity
Takeover other roles / New roles	Expanding roles	Role encroachment / Role extension
How role is seen	Perception	Role perception
Inward looking / Historical roles	Preserving roles	Role validation
Specialist interventions / Developing roles	Justifying roles	

## 8.6 Data analysis stage 6 – Theoretical codes

8.6.1 *Table 8c* illustrates the results from the process of further coding of open codes (1) (moderators), further coding of axial codes (see *Table 8b*), and coding of the initial *a posteriori* categories.

*Table 8c: Descriptive phase data analysis stage 6 (theoretical coding).*

<b>CAUSE</b> Dialogical definition Demographic ignorance Professional ignorance Silo mentality Role Vacuum	<b>CONTEXT</b> Centralisation v. de-centralisation Policy process Resources
Role Tension <b>CONSEQUENCE</b>	Organisational Political conflict Political power and influence <b>PROCESS</b>

## 8.7 Data analysis stage 6a: Selective codes (role enactment moderators)

8.7.1 *Table 8d* illustrates the selective codes, *a posteriori* categories, themes, and the core category that resulted from data analysis stage 6a of moderators of the public health role of community learning disability nurses.

*Table 8d:* Descriptive phase data analysis stage 6a (selective codes – role enactment moderators).

Selective codes	<i>A posteriori</i> categories	Themes	Core category
Unknown population / Definition	Demographic ignorance / Dialogical definition	Demographic ignorance	Individual, professional and organisational moderators
Inter-professional working / Multi-agency working	Multi-professionalism / Multi-agency	Leadership	
Multi-agency working / Specialist roles / Responsibility for policy implementation	Organisations / Change	Organisational issues	
Policy / Service organisation / Decision making / Resources	Policy implementation / Policy formulation	Policy	
Professional roles / Changing roles / Role perception	Expanding roles / Perception / Preserving roles / Justifying roles	Role validation and role clarity	

## 8.8 Data analysis stage 6b: Selective codes (role expectations and policy)

8.8.1 *Table 8e* illustrates the selective codes, themes and public health role categories that resulted from data analysis stage 6b of policy, and public health roles of community learning disability nurses.

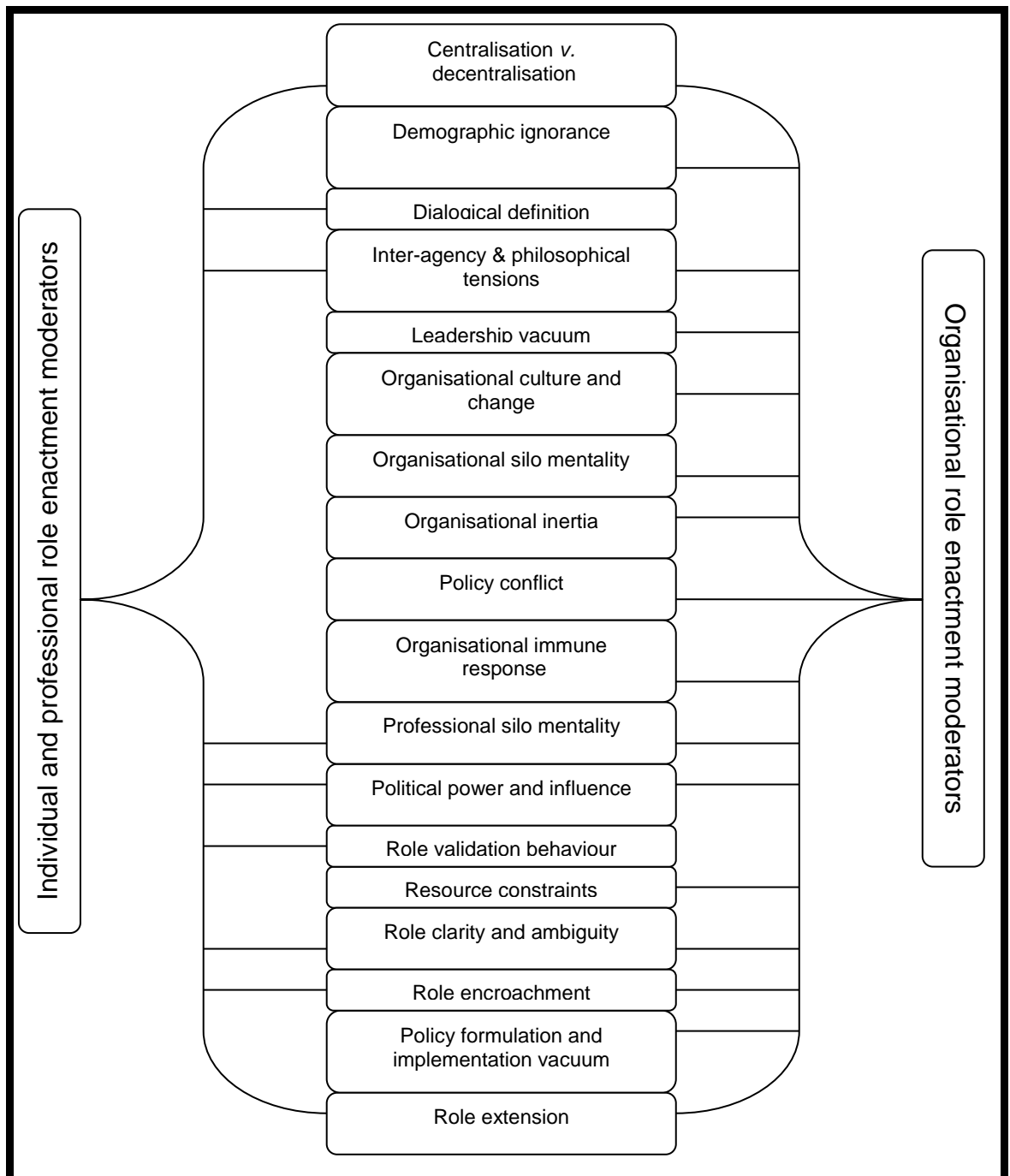
*Table 8e:* Descriptive phase data analysis stage 6b (selective coding – roles and policy)

<b>Themes (policy)</b>	<b>Selective codes</b>	<b>Public health role categories</b>
Learning disability health access	DES LES QOF Same as you SESP Valuing people	Academic  Health education  Health prevention  Health promotion
Public health strategies	Diabetes Sexual health Obesity Smoking cessation	Health protection  Health surveillance  Healthcare access
Policy evaluation and re-design	Six lives Healthcare for all Equal lives	Healthcare delivery  Leadership
Public health policy	All Wales initiative Equally well Investing for health Health challenge Wales Keep well programme Health needs assessment	Policy (development & implementation)

## **8.9 Data analysis stage 7 – Integration**

8.9.1 *Figure 8e* illustrates the integration of categories, and themes (moderators) into two core categories. These core categories were later merged into one core category (see *Figure 8e*).

Figure 8e: Descriptive phase data analysis stage 7 (integrated relationships and core categories).



## 8.10 Data analysis stage 8 – Memoing and diagramming

8.10.1 Tables 8f and 8g illustrate examples of the many memos that were generated during the process of data analysis. Figures 8a, 8b, 8c and 8d illustrate the diagramming of the coding families.

Table 8f: Example of memoing – roles.

	<b>Memos</b>
Role theory	<p>Although role perception, role ambiguity and role clarity influence role enactment, the overall picture is much more complex than role theory has explained thus far. Evidence diagrammed in the coding families suggest that influences on how community learning disability nurses enact their public health roles extent far beyond explanations of role theory and can be grouped into four broad families of cause, context, process, and consequence. To explain this hypothesis it is essential to test the relationships between these influences.</p> <p>29<sup>th</sup> March 2011</p>

Table 8g: Example of memoing – coding families.

<b>Coding Family</b>	<b>Memos</b>
CAUSE	<p>For me constructing and diagramming this coding family has demonstrated that the moderators of public health role enactment extent beyond explanations offered by role theory. There are more significant causes, which are inherent in individual community learning disability nurses, multi-professionalization of public health practice, and how health services are organised.</p> <p>15<sup>th</sup> June 2011</p>
CONTEXT	<p>It appears that explanations of role enactment need to be explained in the contexts in which the specific roles are being enacted.</p>

## 8.11 Summary of findings

8.11.1 Given the evidence presented here, it was reasonable to hypothesise that explanations of how community learning disability nurses enacted their public health roles significantly extended beyond current propositions of role theory.

8.11.2 The moderators of public health role enactment by community learning disability nurses could be grouped into four broad families of **cause, context, process, and consequence**.

8.11.3 The moderators of public health role enactment by community learning disability nurses existed in the **individual, professional, and organisational** contexts.

8.11.4 The public health roles of community learning disability nurses could be categorised as, **academic, health education, health prevention, health promotion, health protection, health surveillance, healthcare access facilitation, healthcare delivery, leadership, and policy development and policy implementation**.

8.11.5 The policies which were relevant to the implementation of public health policy by community learning disability nurses fell into four broad themes of **learning disability health access, public health strategies, policy evaluation and re-design, and public health policy**.



## 8.12 Conclusion

8.12.1 In this phase of the study, findings seemed to suggest that moderators of public health role enactment by community learning disability nurses extended beyond current propositions of role theory. These findings demonstrated that there were four broad families of cause, context, process, and consequence that moderated how community learning disability nurses who participated in this study enacted their public health roles. To better understand these moderators it was important to test the one directional hypothesis given below in order to explain some of their relationships.

### ***Key findings***

**Public health role enactment by community learning disability nurses is influenced by individual factors, professional factors and organisational factors.**

## Chapter 9: Results 3 – Questionnaire survey (explanatory phase)

### Introduction

In this chapter I present the findings and my conclusions from the explanatory phase of the study. Reporting survey research results is quite different from the documentary and grounded theory methods used in stages 1 and 2 of the study. The main difference is that in reporting the results in this stage I had to follow the positivist protocol (Fink 2003a).

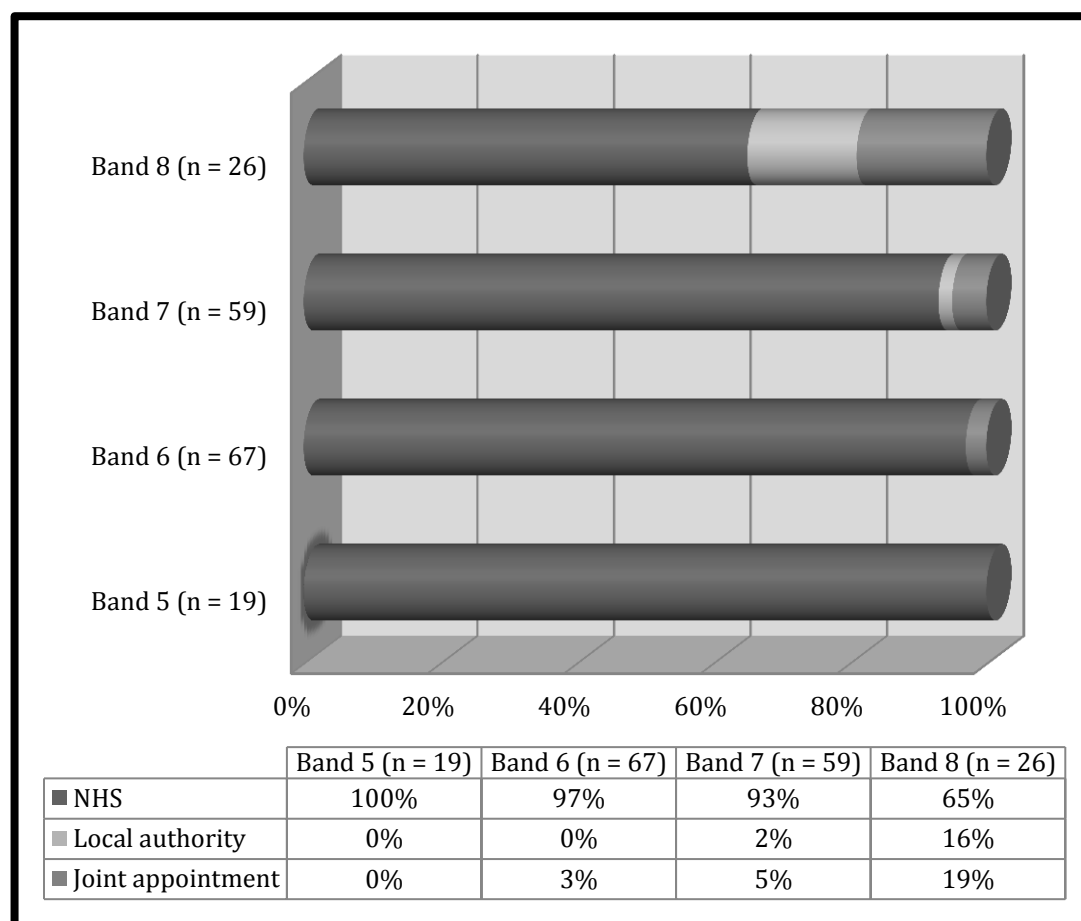
In chapter 6 I detailed my approach and rationale to data analysis and identified all the statistical analyses undertaken. In presenting the results I used the process outlined in chapter 6. In addition, where appropriate I report the results in relation to specific items of the survey questionnaire.

#### *Box 9a: Interpretation of mean scores*

For single item scores, the median score was 3. Scores below 3 indicated a degree of agreement. Scores above 3 indicated a degree of disagreement. For combined scores, the median score was 21. Scores below 21 indicated a degree of agreeableness. Scores above 21 indicated a degree of disagreeableness. However, an overall score below 21 may be misleading. Combined mean scores needed to be reported in conjunction with mean scores for individual items to ensure that degrees of disagreeableness of individual mean scores were reported.

## 9.1 Nurse distribution by band and employer

Figure 9a: Nurse distribution by band and employer.



9.1.1 Of the band 5 community learning disability nurses who participated in this part of the study, 100% ( $n = 19$ ) were employed in NHS organisations. 97% ( $n = 67$ ) of band 6 nurses were employed in NHS organisations, and 3% had joint appointments. 93% ( $n = 59$ ) of band 7 nurses were employed in NHS organisations; 2% were employed in local authority organisations, and 5% had joint appointments. 65% ( $n = 26$ ) of band 8 nurses were employed in NHS organisations; local authorities employed 16%, and 19% had joint appointments.

- 9.1.2 It appears that in the population under study there was a relationship between the band, and the employing organisation. Significantly, less band 8 nurses exclusively worked for the NHS (65%) as compared to 93% (band 7), 97% (band 6), and 100% (band 5).

## 9.2 Explanatory phase questionnaire reliability test results

- 9.2.1 *Table 9a* shows that the overall Cronbach's alpha coefficient was .714. This suggests that the survey questionnaire has very good internal consistency reliability as a scale for the sample of participants surveyed. As said earlier, this was a new scale, and no comparisons of the Cronbach's alpha coefficient could be made.

*Table 9a:* Explanatory phase questionnaire reliability test results.

Cronbach's Alpha	Items	Variables
<b>.714</b>	<b>7</b>	<b>Q1 Q2 Q3 Q4 Q5 Q7 Q8</b>
.675		
(Based on standardised items)		
.632	6	Q1 Q3 Q4 Q5 Q7 Q8
.651	6	Q1 Q2 Q4 Q5 Q7 Q8
.688	6	Q1 Q2 Q3 Q5 Q7 Q8
.739	6	Q1 Q2 Q3 Q4 Q7 Q8
.743	6	Q1 Q2 Q3 Q4 Q5 Q8
.642	6	Q1 Q2 Q3 Q4 Q5 Q7

### **9.3 Correlations**

9.3.1 The correlation matrices are presented in *Appendix 9a* and *Appendix 9b*. The test using the Friedman's two-way analysis of variance by ranks showed that there were positive correlations between role clarity, role review, daily activities, role perception, role value, perceptions of employers' priorities, and perceptions of employers' knowledge of the public health needs of people with learning disabilities which influenced how community learning disability nurses enacted their public health roles. Overall, the relationships between the variables were positive and significant. *Table 9b* shows the interpretations of the relationships between these variables.

Table 9b: Interpretations of the relationships between variables (Stage 3)

Pearson correlations ( <i>n</i> =171)	<i>r</i>	Significance	Interpretation (Cohen 1988)
Employer and band	<i>r</i> =.29	<i>p</i> <0.01 ( <i>Sig.</i> = .000, <i>n</i> = 171, <i>p</i> <0.05)	small
Employer and daily activities	<i>r</i> =.36	<i>p</i> <0.01 ( <i>Sig.</i> = .000, <i>n</i> = 171, <i>p</i> <0.05)	medium
Employer and perceptions of employer's priorities	<i>r</i> =.21	<i>p</i> <0.01 ( <i>Sig.</i> = .007, <i>n</i> = 171, <i>p</i> <0.05)	small
Employer and perceptions of employer's knowledge	<i>r</i> =.21	<i>p</i> <0.01 ( <i>Sig.</i> = .003, <i>n</i> = 171, <i>p</i> <0.05)	small
Role clarity and role review	<i>r</i> =.55	<i>p</i> <0.01 ( <i>Sig.</i> = .000, <i>n</i> = 171, <i>p</i> <0.05)	large
Role clarity and daily activities	<i>r</i> =.56	<i>p</i> <0.01 ( <i>Sig.</i> = .000, <i>n</i> = 171, <i>p</i> <0.05)	large
Role clarity and perceptions of employer's priorities	<i>r</i> =.38	<i>p</i> <0.01 ( <i>Sig.</i> = .000, <i>n</i> = 171, <i>p</i> <0.05)	medium
Role clarity and perceptions of employer's knowledge	<i>r</i> =.42	<i>p</i> <0.01 ( <i>Sig.</i> = .000, <i>n</i> = 171, <i>p</i> <0.05)	medium
Role review and daily activities	<i>r</i> =.32	<i>p</i> <0.01 ( <i>Sig.</i> = .000, <i>n</i> = 171, <i>p</i> <0.05)	medium
Role review and perceptions of employer's priorities	<i>r</i> =.41	<i>p</i> <0.01 ( <i>Sig.</i> = .000, <i>n</i> = 171, <i>p</i> <0.05)	medium
Role review and perceptions of employer's knowledge	<i>r</i> =.46	<i>p</i> <0.01 ( <i>Sig.</i> = .000, <i>n</i> = 171, <i>p</i> <0.05)	medium
Daily activities and perceptions of employer's priorities	<i>r</i> =.25	<i>p</i> <0.01 ( <i>Sig.</i> = .001, <i>n</i> = 171, <i>p</i> <0.05)	small
Daily activities and perceptions of employer's knowledge	<i>r</i> =.35	<i>p</i> <0.01 ( <i>Sig.</i> = .000, <i>n</i> = 171, <i>p</i> <0.05)	small
Role perception and role value	<i>r</i> =.62	<i>p</i> <0.01 ( <i>Sig.</i> = .000, <i>n</i> = 171, <i>p</i> <0.05)	large
Perceptions of employer's priorities and band	<i>r</i> =.24	<i>p</i> <0.01 ( <i>Sig.</i> = .002, <i>n</i> = 171, <i>p</i> <0.05)	small
Perceptions of employer's priorities and perceptions of employer's knowledge	<i>r</i> =.38	<i>p</i> <0.01 ( <i>Sig.</i> = .000, <i>n</i> = 171, <i>p</i> <0.05).	medium

## 9.4 ANOVA

- 9.4.1 The first Levene's test for homogeneity of variances tested whether the variance in scores was the same for each of the bands.

*Table 9c:* Levene's statistic test results (band)

<b>Levene Statistic</b>	<b>df1</b>	<b>df2</b>	<b>Sig.</b>
1.124	3	167	.341

The significance value (Sig.) needed to be greater than .05 (Pallant 2007). In this study the Sig. value was .341 (see *Table 9c*). Since this was greater than .05, the homogeneity of variance assumption was not violated, and the variability of the scores for each of the four groups was similar.

- 9.4.2 The first ANOVA gave between between-bands, and within-bands sums of squares, degrees of freedom, F ratio, and significance (Sig.) (see *Table 9d*).

*Table 9d:* Between bands ANOVA test results

	<b>df</b>	<b>F</b>	<b>Sig.</b>
Between Groups	3	4.238	.006
Within Groups	167		
Total	170		

If the Sig. value was less than, or equal to 0.05 there was a significant difference among the means of the bands (Pallant 2007). In this study the Sig. value was .006, which was less

than .05. This indicated that there was a statistically significant result within the bands.

9.4.3 Post-hoc comparisons were used to explore the differences between the bands. This test revealed that there were significant differences between the bands  $F(3, 167) = 4.238, p < .05$ . The overall Sig. value was .006, which was less than .05.

*Table 9e: Tukey's HSD post-hoc test results (band)*

<b>Band</b>	<b>Band</b>	<b>Mean Difference</b>	<b>Sig.</b>
<b>Band5</b>	<b>Band6</b>	.92028	.833
	<b>Band7</b>	.15608	.999
	<b>Band8</b>	-2.52429	.196
<b>Band6</b>	<b>Band5</b>	-.92028	.833
	<b>Band7</b>	-.76420	.739
	<b>Band8</b>	-3.44457*	.003
<b>Band7</b>	<b>Band5</b>	-.15608	.999
	<b>Band6</b>	.76420	.739
	<b>Band8</b>	-2.68037*	.038
<b>Band8</b>	<b>Band5</b>	2.52429	.196
	<b>Band6</b>	3.44457*	.003
	<b>Band7</b>	2.68037*	.038

\* The mean difference is significant at the 0.05 level.

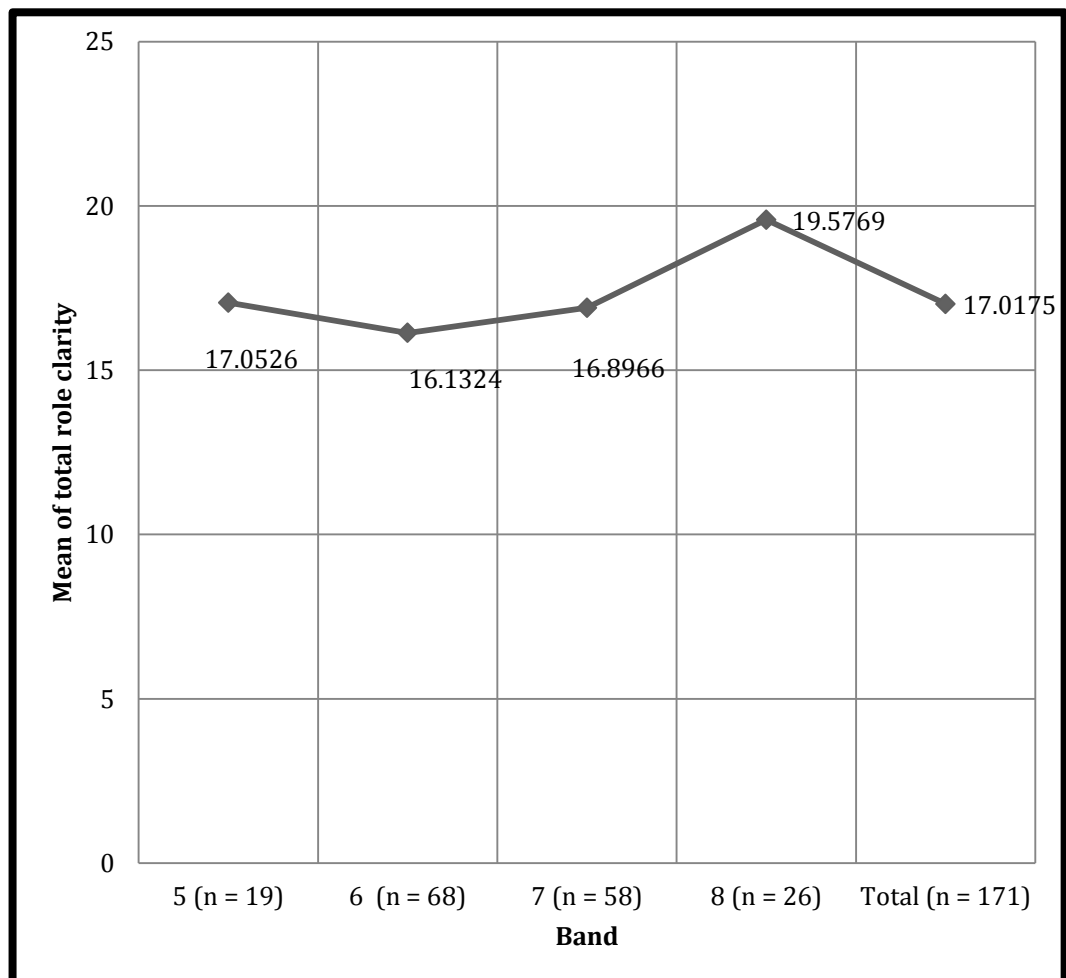
Between band 6 and band 8 the Sig. value was .003, which was significant at the  $p < .05$  level (see *Table 9e*). This indicated a significant difference between the groups. Between band 7 and band 8 the Sig. value was .038.



This indicates a significant difference between the two groups at the  $p < .05$  level.

9.4.4 The means plot (see *Figure 9b*) illustrates the differences between the mean scores for the different bands.

*Figure 9b: Means plot (band).*



9.4.5 The second Levene's test for homogeneity of variances tested whether the variance in scores was the same for each of the employer groups. The significance value (Sig.) needed to be greater than .05 (Pallant 2007). In this study the Sig. value was .849 (see *Table 9f*). Since this was greater than .05, the homogeneity of variance assumption was not violated.

*Table 9f: Levene's statistic test results (employer).*

Levene Statistic	df1	df2	Sig.
.164	2	168	.849

9.4.6 The second ANOVA gave between-employer groups and within-employer groups sums of squares, degrees of freedom, F ratio, and significance (Sig.). If the Sig. value was less than or equal to 0.05 there was a significant differences among the means on the dependent variable for the employer groups.

*Table 9g: Between employer groups ANOVA test results.*

	df	F	Sig.
Between Groups	2	8.527	.000
Within Groups	168		
Total	170		

In this study the Sig. value was .000, which was less than .05. This indicated that there was a statistically significant result within the groups.

9.4.7 Post-hoc comparisons were used to explore the differences between the employer groups.

*Table 9h: Tukey's HSD post-hoc test results (employer).*

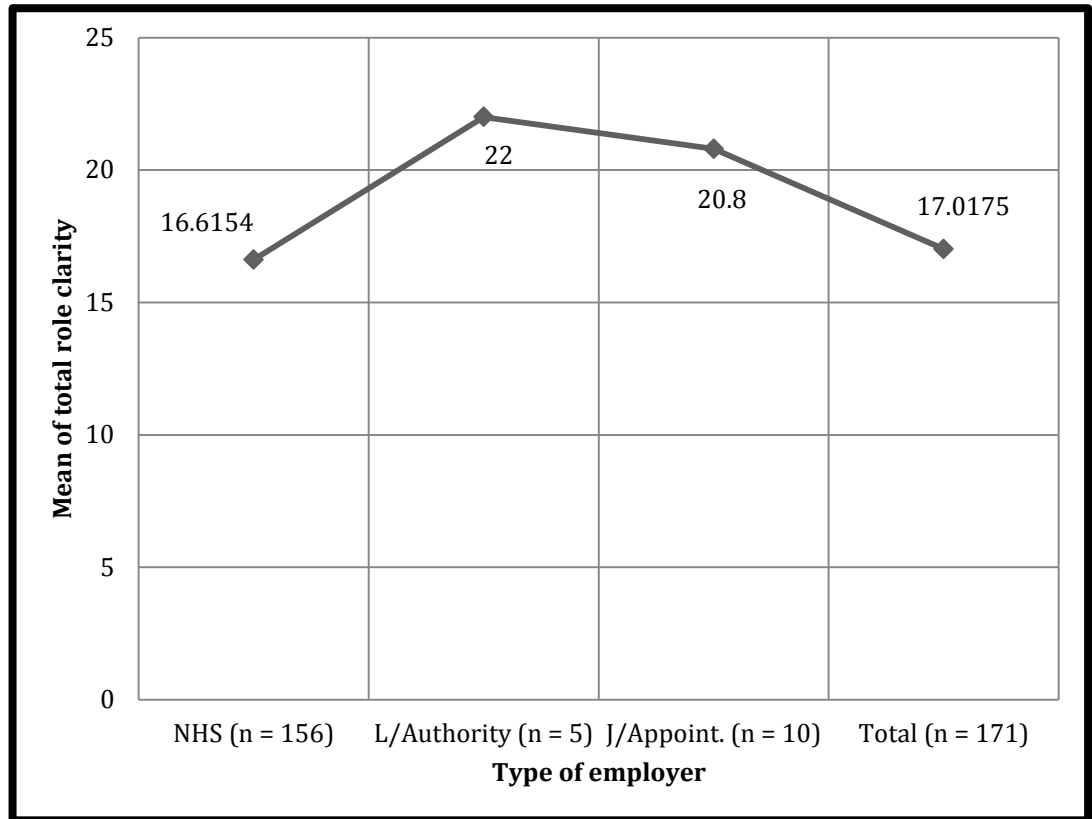
Employer	Employer	Mean Difference	Sig.
NHS	Local	-5.38462*	.013
	Authority		
	Both	-4.18462*	.006
Local Authority	NHS	5.38462*	.013
	Both	1.20000	.857
Both	NHS	4.18462*	.006
	Loc. Authority	1.20000	.857

\* The mean difference is significant at the 0.05 level.

The overall Sig. value was .000, which was less than .05 (see *Table 9g*). Between the NHS and the local authority the Sig. value was .013. This indicated a significant difference between the employer groups. Between the NHS and Both the Sig. value was .006. This indicated a significant difference between the two employer groups.

9.4.8 The means plot (see *Figure 9b*) illustrates the differences between the mean scores for the different employer groups.

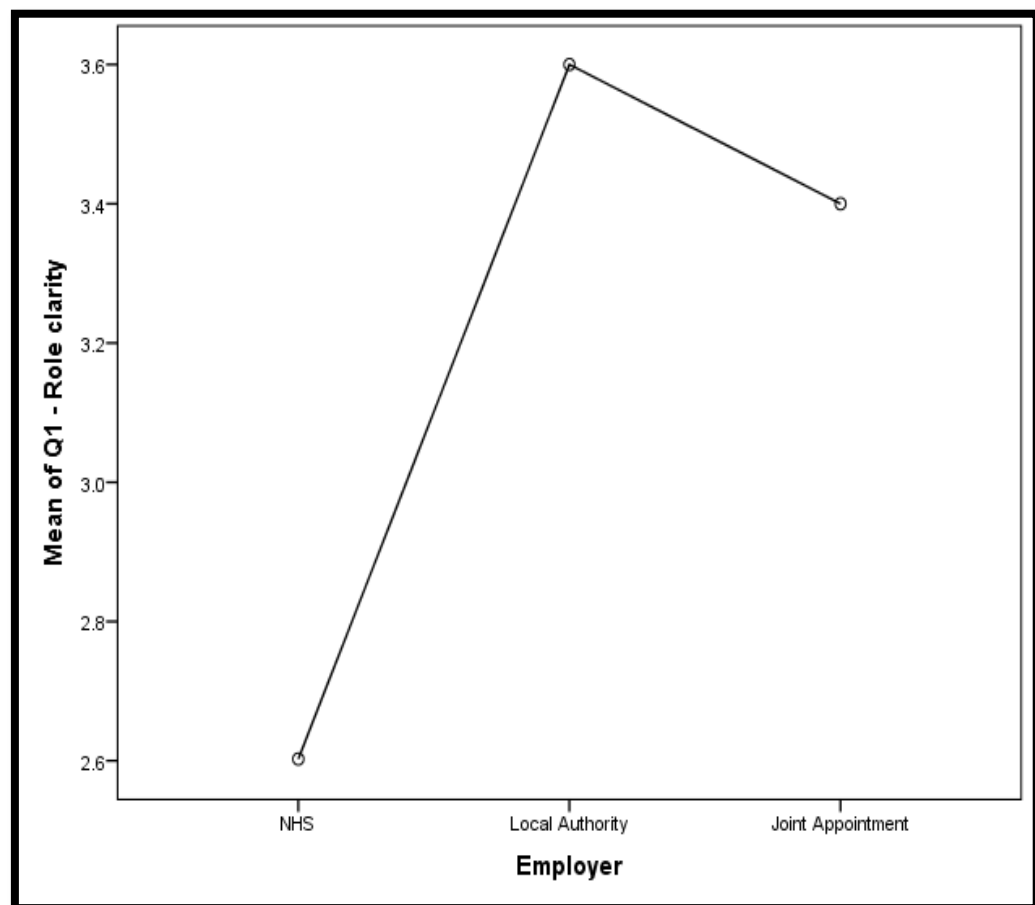
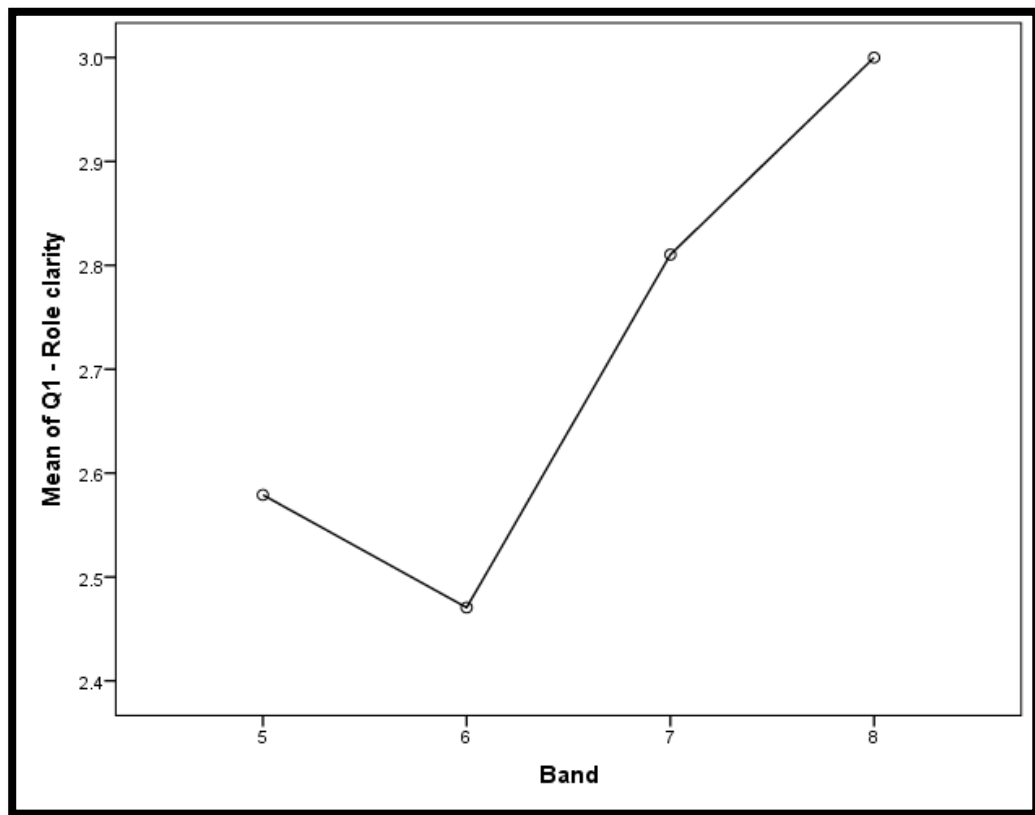
Figure 9c: Means plot (type of employer).



## 9.5 Role clarity in job description *(My public health role is clearly defined in my job description / person specification / work schedule.)*

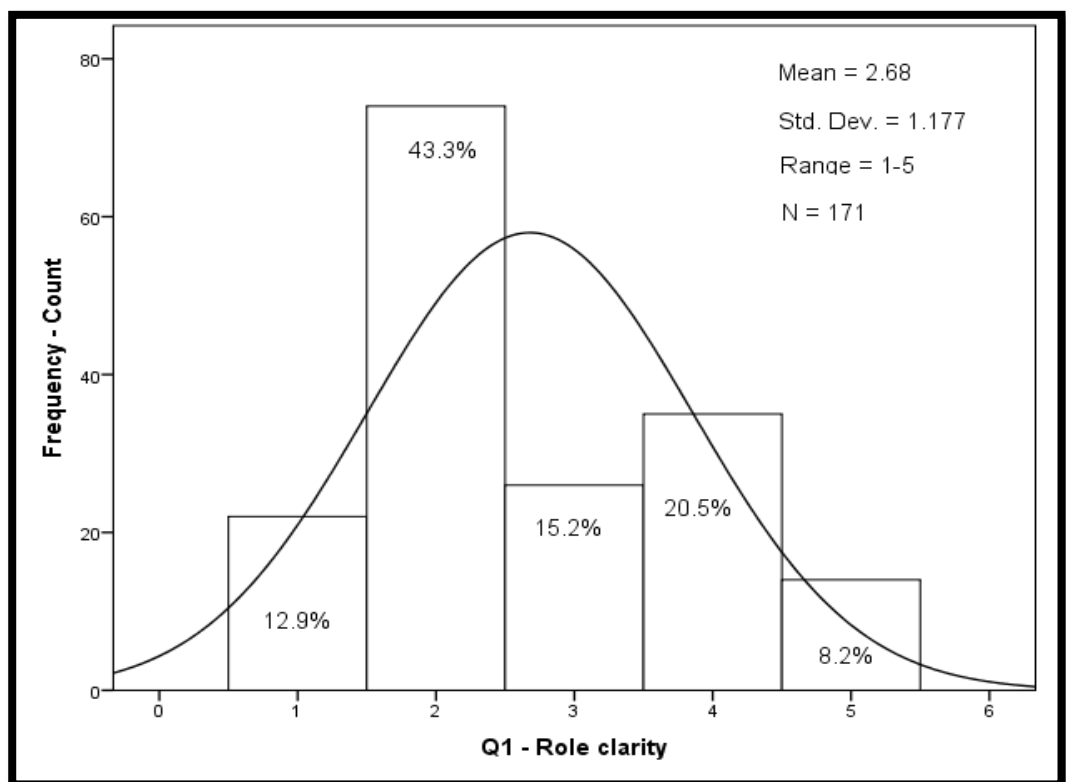
9.5.1 This item measured how clear public health role expectations were in the nurses' job descriptions person specifications, or any other work schedules. The means plot show that the mean score (3.0) for public health role clarity for band 8 nurses is higher than those for all the other groups (see *Figure 9d*). This is significant between band 8, and bands 5 and 6. The higher mean score means that band 8 nurses felt that their public health roles are unclear in their job descriptions.

Figure 9d: Role clarity in job descriptions means plots.



9.5.2 On the other hand the mean scores for public health role clarity as measured against type of employer suggested that public health roles for nurses working in the local authority and those in dual appointments were significantly less clear (Mean score 3.6). *Figure 9d1* illustrates the distribution of scores for question 1 (Q1). This shows that 28.7% of participants either disagreed or strongly disagreed that their public health roles were clear in their job descriptions.

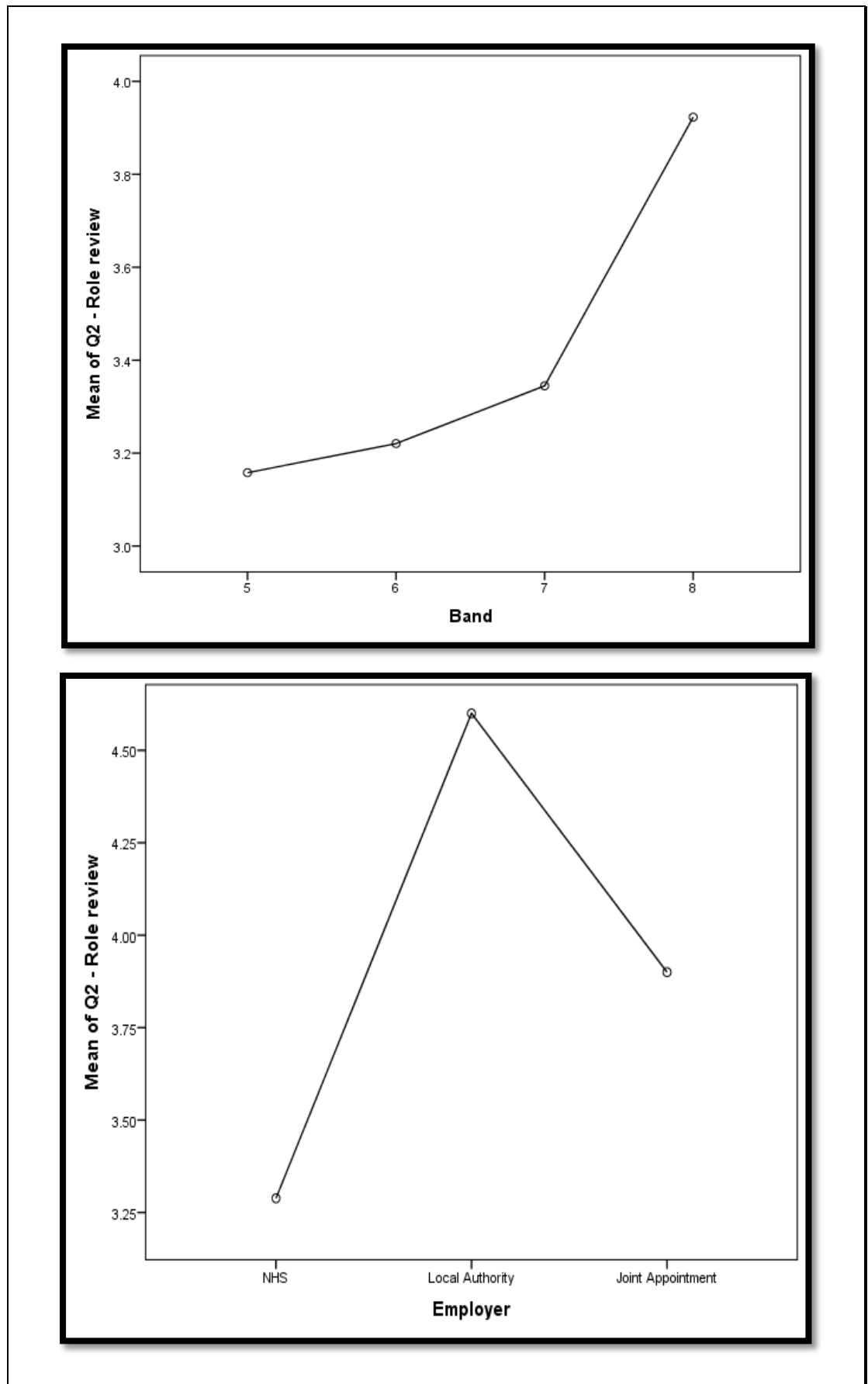
*Figure 9d1: Distribution of scores for Q1 – ‘role clarity in job descriptions’.*



**9.6 Role review** (*My job description and or person specification are regularly reviewed to take account of emerging public health and other policies*).

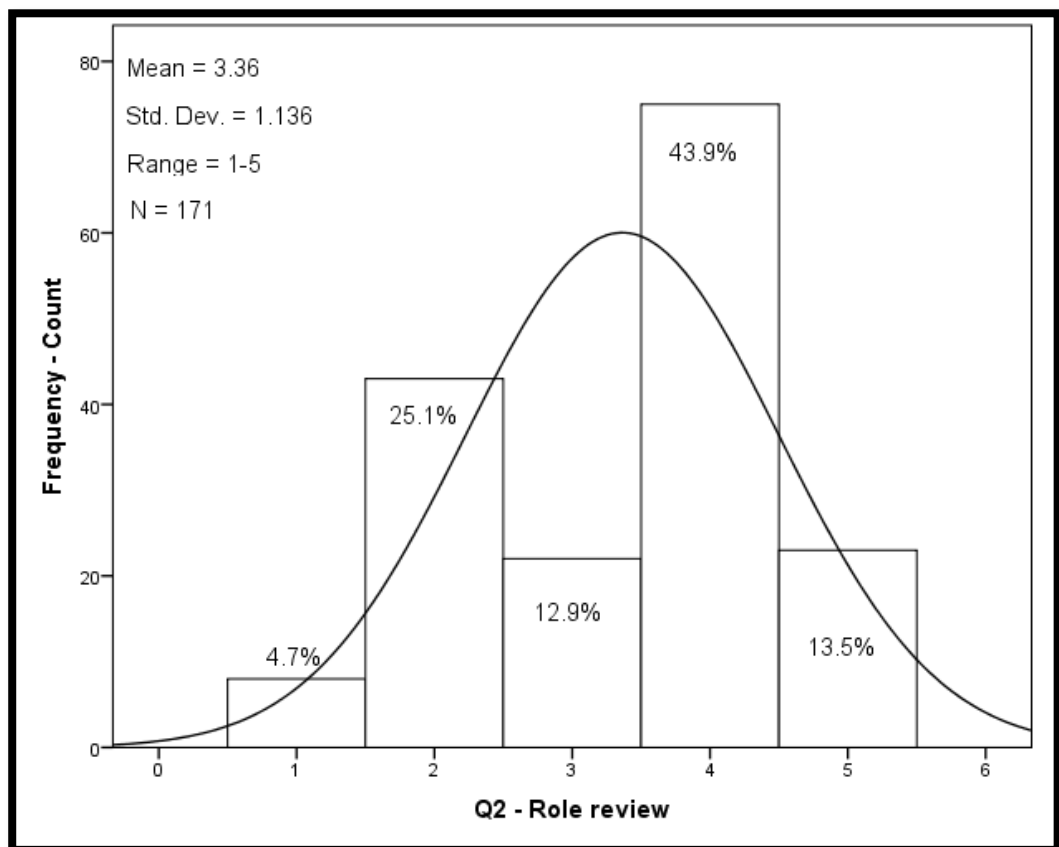
9.6.1 This item measured community learning disability nurses' experience of how often their job descriptions and person specifications were reviewed in response to emerging public health policies.

Figure 9e: Role review means plots



9.6.2 The plots show that the mean score (3.9) for band 8 nurses is higher than those for all the other groups (see *Figure 9e*). The higher mean score means that band 8 nurses felt that their job descriptions were not regularly reviewed to take account of emerging public health public health initiatives. On the other hand, the mean score (4.1) for role review as measured against type of employer suggested that nurses employed by local authorities strongly disagreed that their job descriptions and job roles were reviewed in line with emergent public health policy. Figure 9e1 shows that 57.4% of participants disagreed or strongly disagreed that their public health roles in their job descriptions were regularly reviewed (Mean = 3.36; Std. Dev. = 1.136; Range = 1-5;  $n = 171$ ).

*Figure 9e1: Distribution of scores for Q2 – ‘role review’.*





**9.7 Daily activities** (*My day-to-day activities are consistent with my job description and or person specification*).

9.7.1 This item measured the consistency between job descriptions, person specifications, or any other work schedule and community learning disability nurses' day to day public health activities. The plots show that the mean score for band 8 nurses is higher than those for all the other groups. However this is insignificant since this is below the median score of 3.0 (see *Figure 9f*). The higher mean score does not show that band 8 nurses felt that their job descriptions were not regularly reviewed to take account of emerging public health initiatives. It is important to note that these results were from a relatively small sample.

9.7.2 On the other hand the mean score (3.7) for role review as measured against type of employer suggested that nurses employed by local authorities strongly disagreed that their job descriptions and job roles were reviewed in line with emergent public health policy.

9.7.3 Figure 9f1 illustrates the distribution of scores for question 3 (Q3). It is important to note that 74.3% of the participants reported that their daily activities were consistent with their job descriptions or person specifications. However, it is also important to note the significant proportion (25.7%) (Mean = 2.37; Std. Dev. 1.057; Range = 1-5;  $n = 171$ ) of participants who were not sure, disagreed, or strongly disagreed.

Figure 9f: Daily public health role activities means plots.

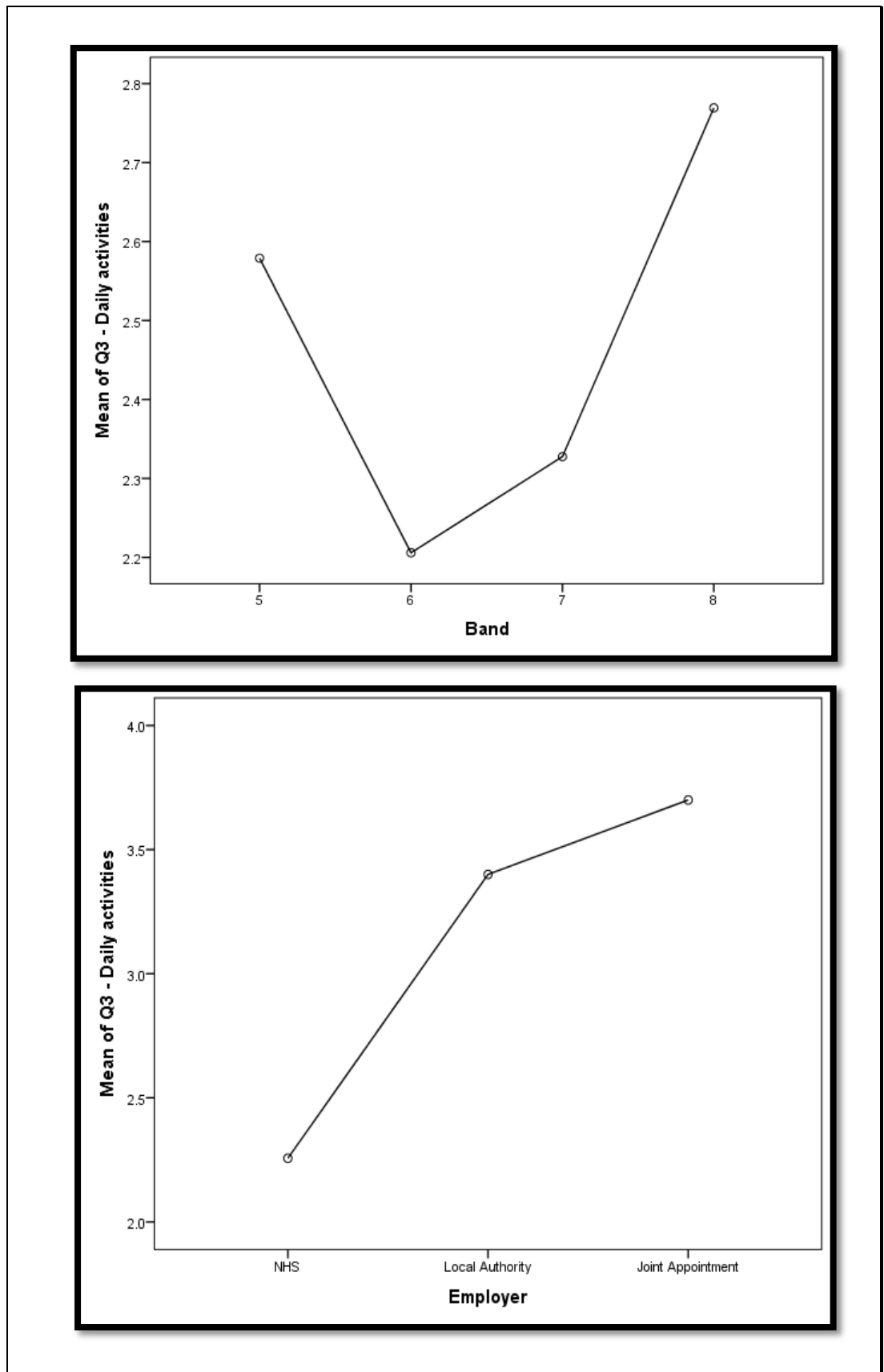
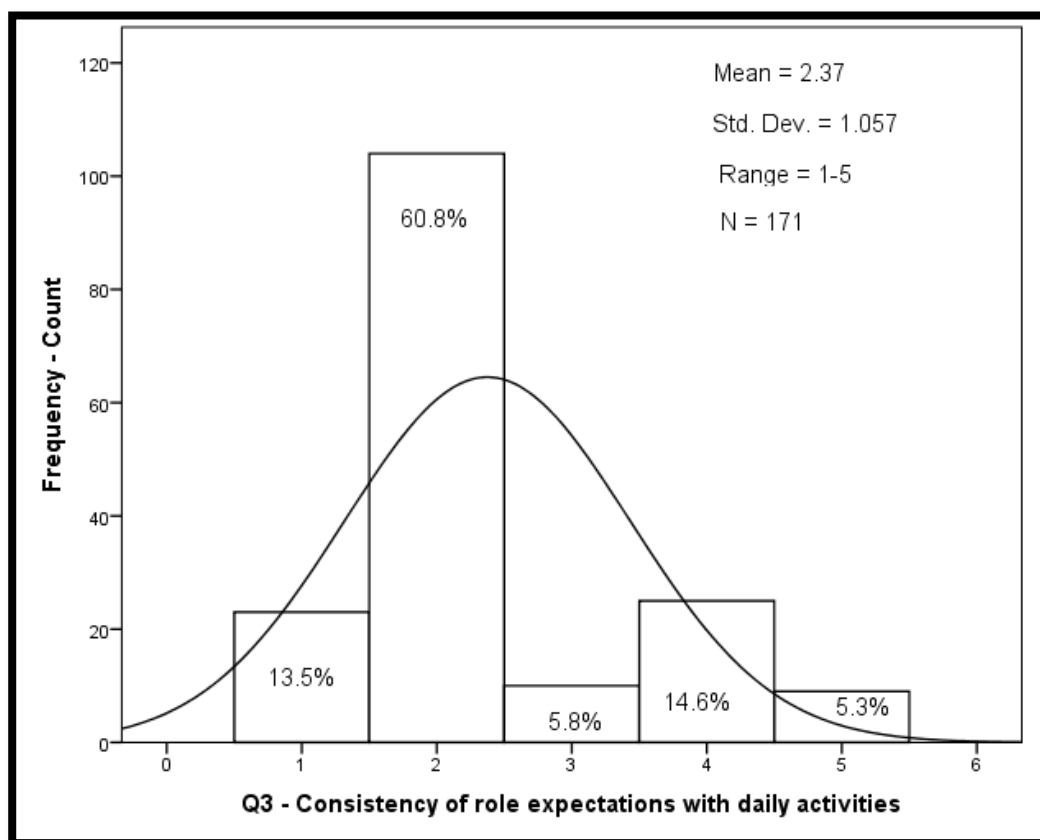


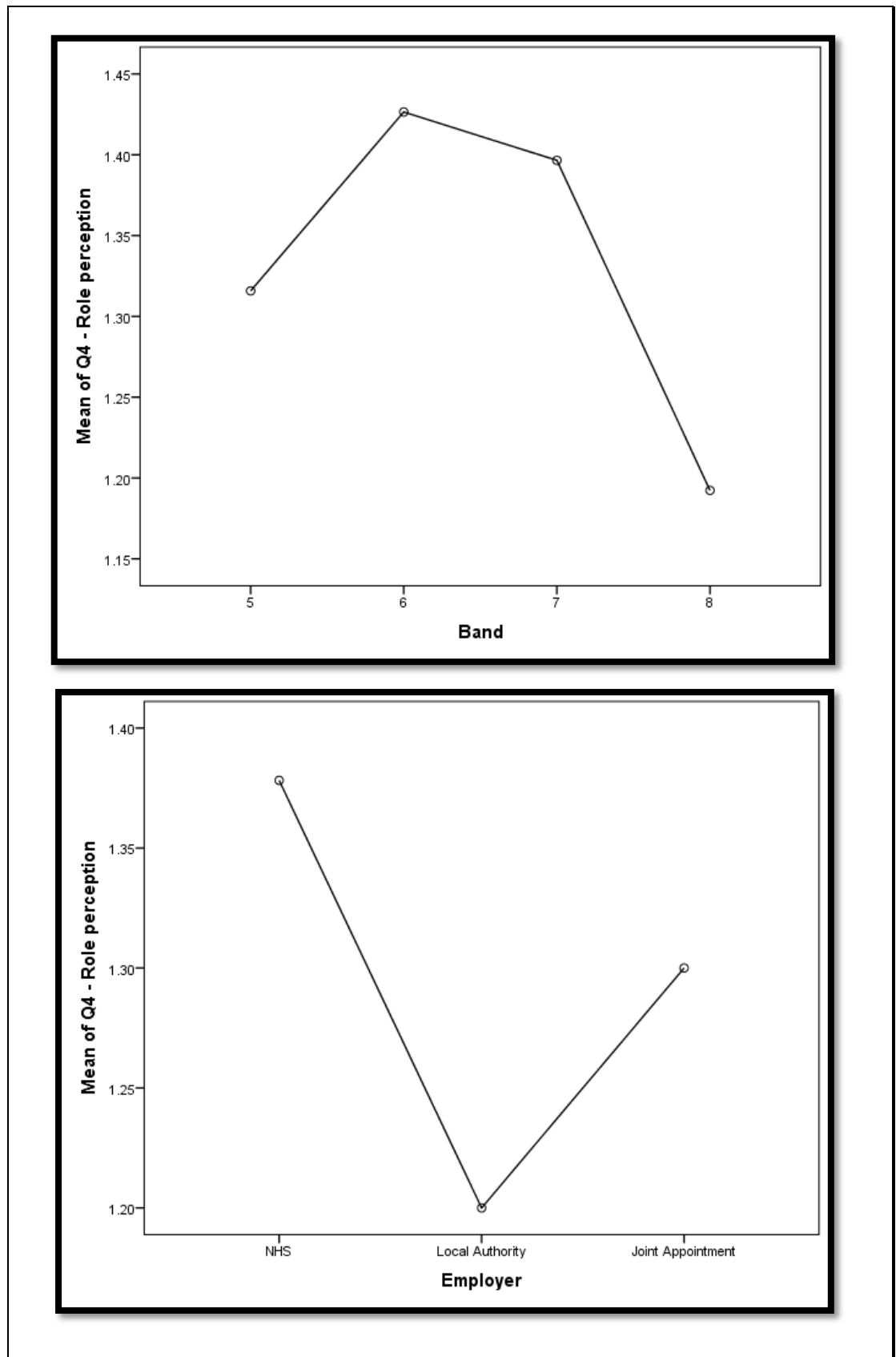
Figure 9f1: Distribution of scores for Q3 – ‘consistency of role expectations with daily activities’.



## 9.8 Role perception *(Learning disability nurses have or should have a key role in implementing public health policy for people with learning disabilities).*

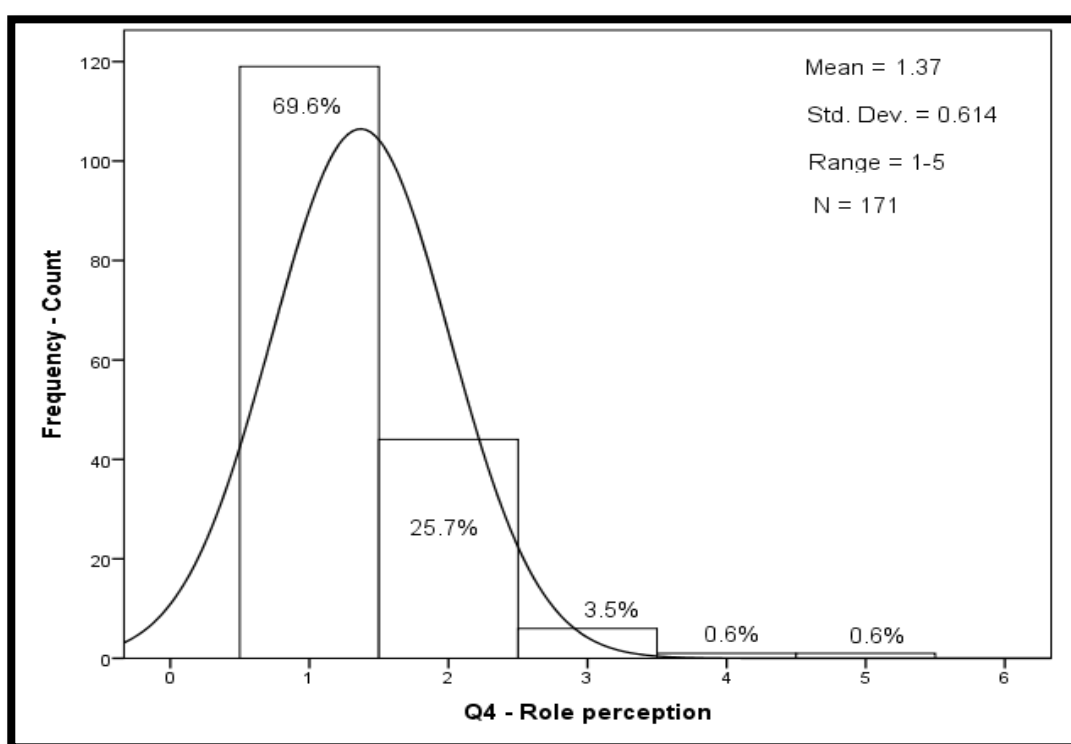
9.8.1 Figure 9g shows that the mean scores for role perception were significantly positive for both band and type of employer. The plots show that the mean score for band 6 and 7 nurses were higher than those for all the other groups (see Figure 9g). On the other hand, the mean score for role perception as measured against type of employer was highest for nurses employed by local authorities. However this has to be viewed in the context of small numbers of sampled community learning disability nurses who worked in local authorities.

Figure 9g: Role perception means plots.



9.8.2 *Figure 9g1* shows that 95.3% of participants agreed or strongly agreed that they had a positive perception of their public health roles (Mean = 1.37; Std. Dev. = 0.614; Range = 1-5;  $n = 171$ ).

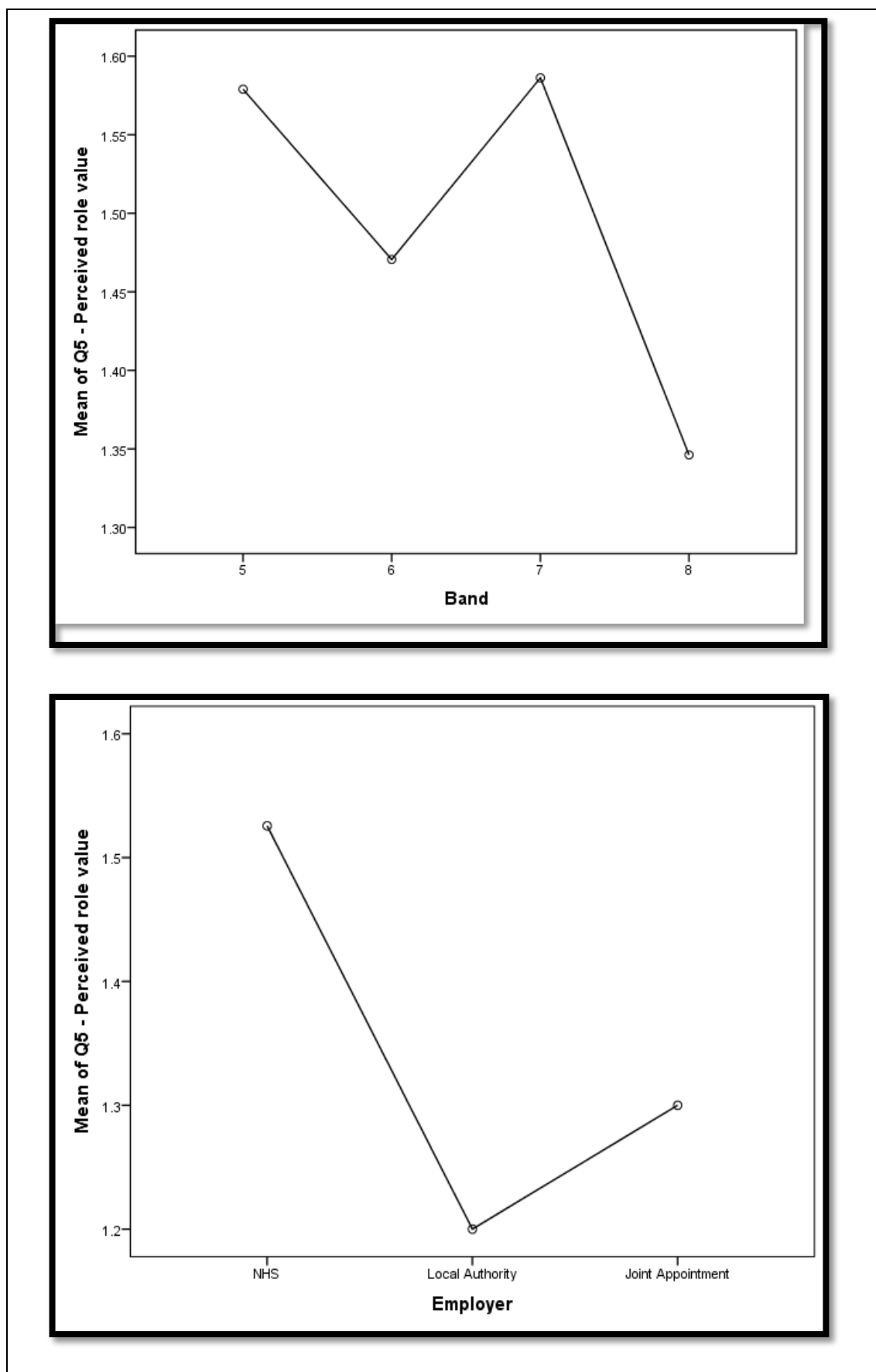
*Figure 9g1: Distribution of scores for Q4 – ‘role perception’.*



## 9.9 Perceived role value *(Delivering public health services for people with learning disabilities is an important role for the learning disability nurse).*

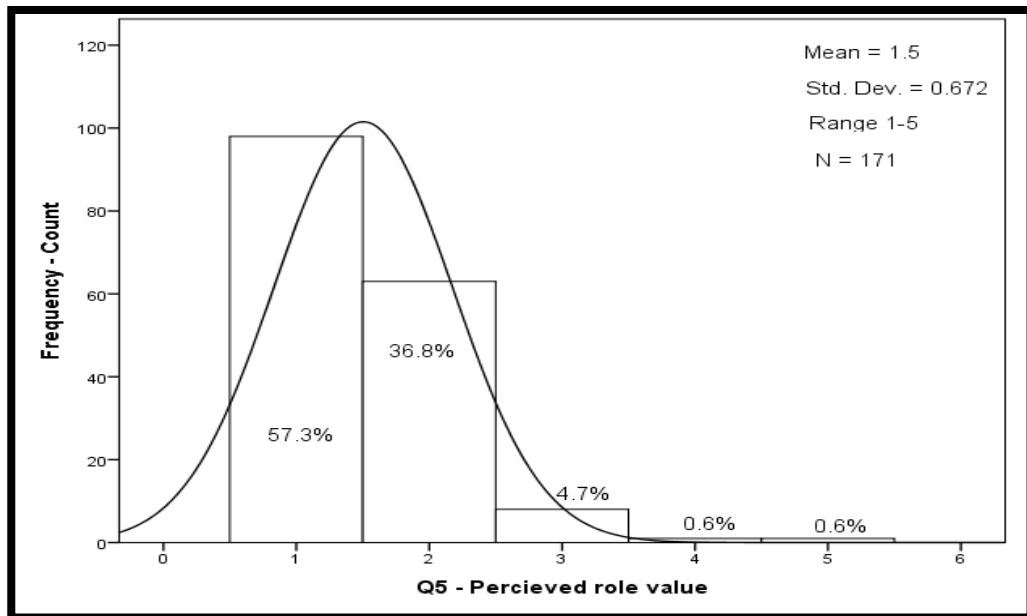
9.9.1 The means plots show that the mean scores for role value / importance were significantly positive for both band and type of employer. The plots show that the mean score for band 5 and 7 nurses were higher than those for all the other groups (see *Figure 9h*). On the other hand the mean score for role review as measured against type of employer suggested was lowest for nurses employed by local authorities. However, this has to be viewed in the context of small numbers of nurses who work in local authorities.

Figure 9h: Perceived role value means plots



9.9.2 *Figure 9h1* shows that 94.1% of participants agreed or strongly agreed that delivering public health services for people with learning disabilities was an important role for the learning disability nurse (Mean = 1.5; Std. Dev. = 0.672; Range = 1-5;  $n = 171$ ).

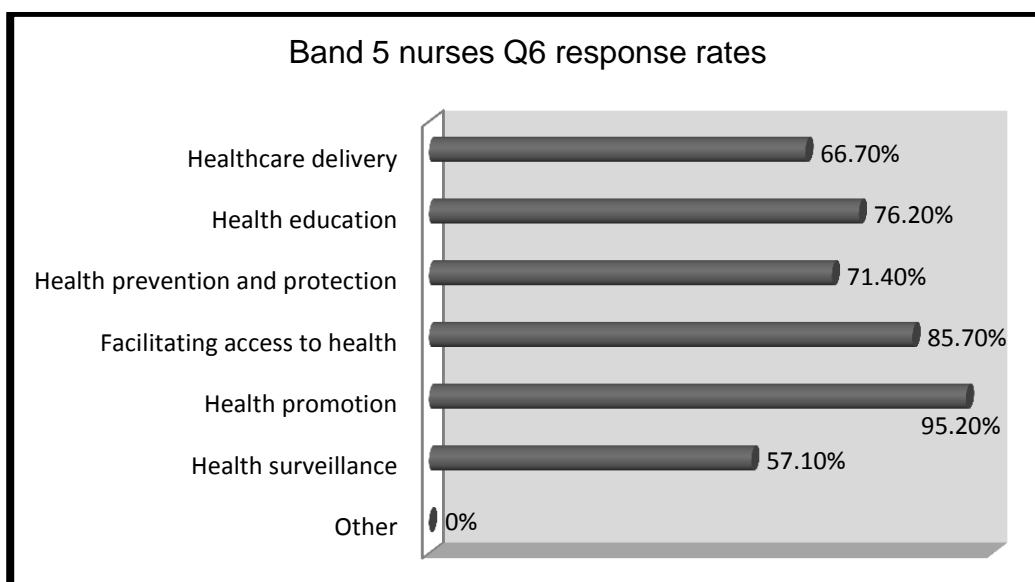
*Figure 9h1: Distribution of scores for Q5 – ‘perceived role value’.*



**9.10 Public health roles** (*My role as a community learning disability nurse involves the following (healthcare delivery; health education; health prevention and protection; facilitating access to health; health promotion; health surveillance)*).

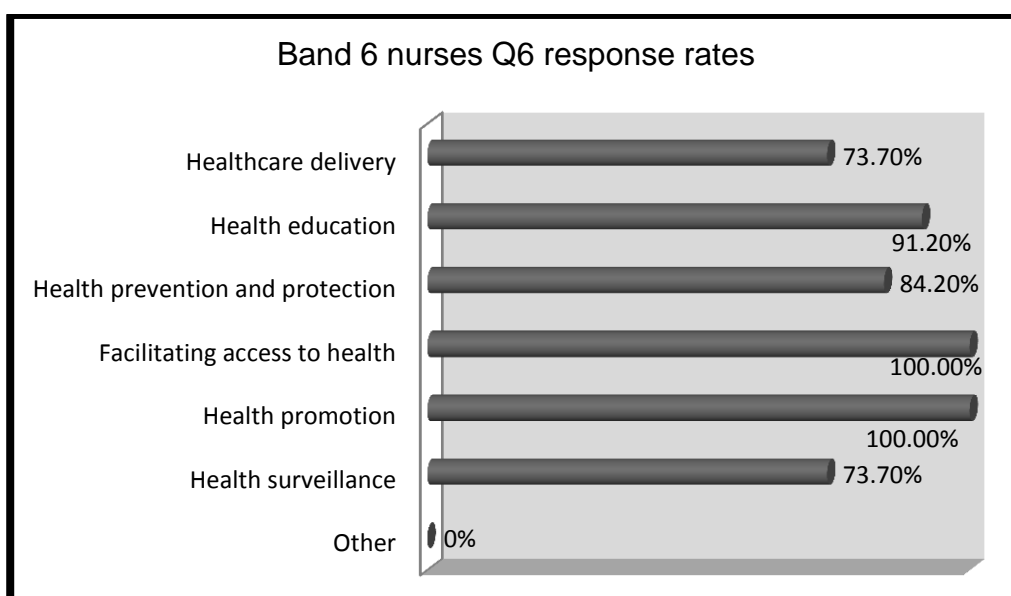
9.10.1 Of the band 5 participants who participated in this study the most common public health activity was health promotion, with 95.2% of the respondents reporting that they participated in this role. Health surveillance was the least public health role band 5 community learning disability nurses engaged with 57.1% of the participants reporting some level of involvement and participation (see *Figure 9i*).

Figure 9i: Band 5 nurses' involvement with public health.



9.10.2 Of the band 6 participants who took part in this study, 100% of the respondents reported that they participated in health promotion and in facilitating access to health services. Health surveillance and healthcare delivery were the least public health roles band 6 community learning disability nurses engaged in, with 73.7% of the participants reporting some level of involvement and participation in both roles (see Figure 9j).

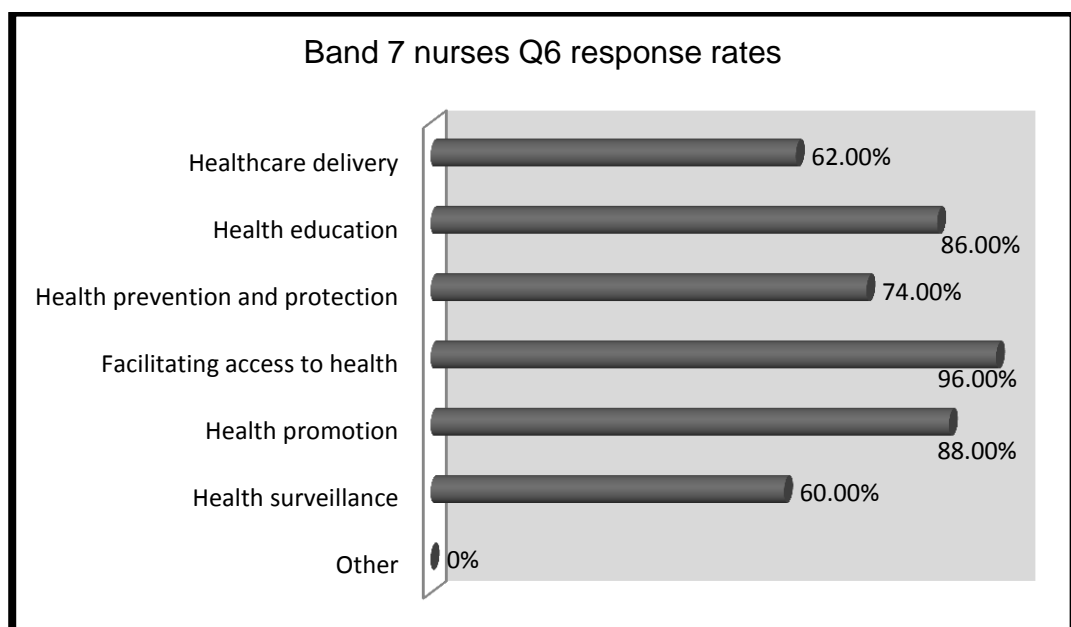
Figure 9j: Band 6 nurses' involvement with public health.





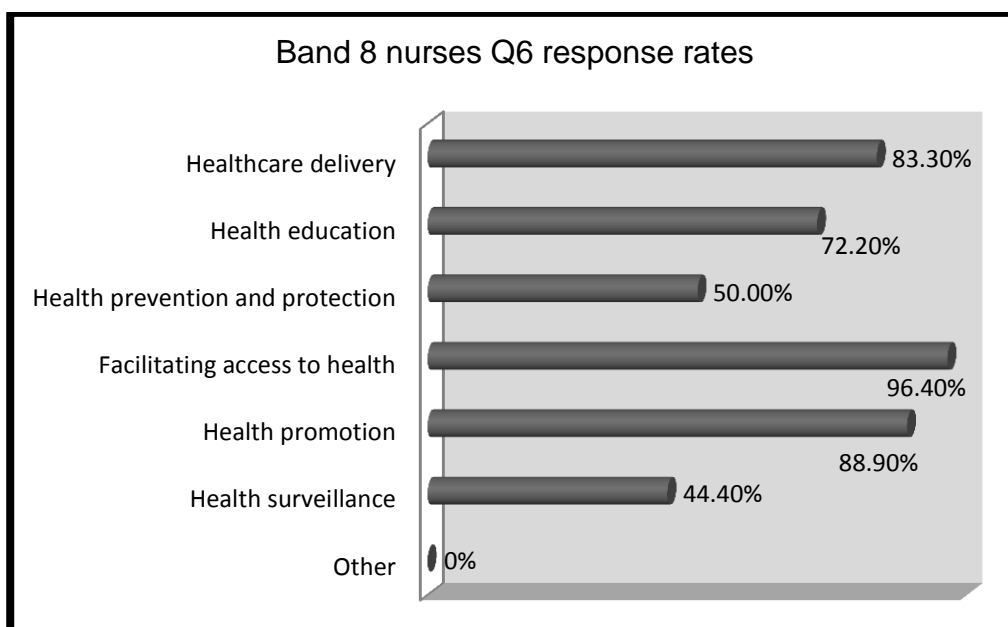
9.10.3 Of the band 7 participants who participated in this study the most common public health activity was facilitating access to health, with 96% of the respondents reporting that they participated in this role in some way (see *Figure 9k*). At 60% health surveillance was the least public health role band 7 community learning disability nurses engaged in.

*Figure 9k: Band 7 nurses' involvement with public health.*



9.10.4 Of the band 8 participants who participated in this study the most common public health activity was facilitating access to health, with 94.4% of the respondents reporting that they participated in this role in some way. Health surveillance was the least public health role band 8 community learning disability nurses engaged with 44.4% of the participants reporting some level of involvement and participation (see *Figure 9l*).

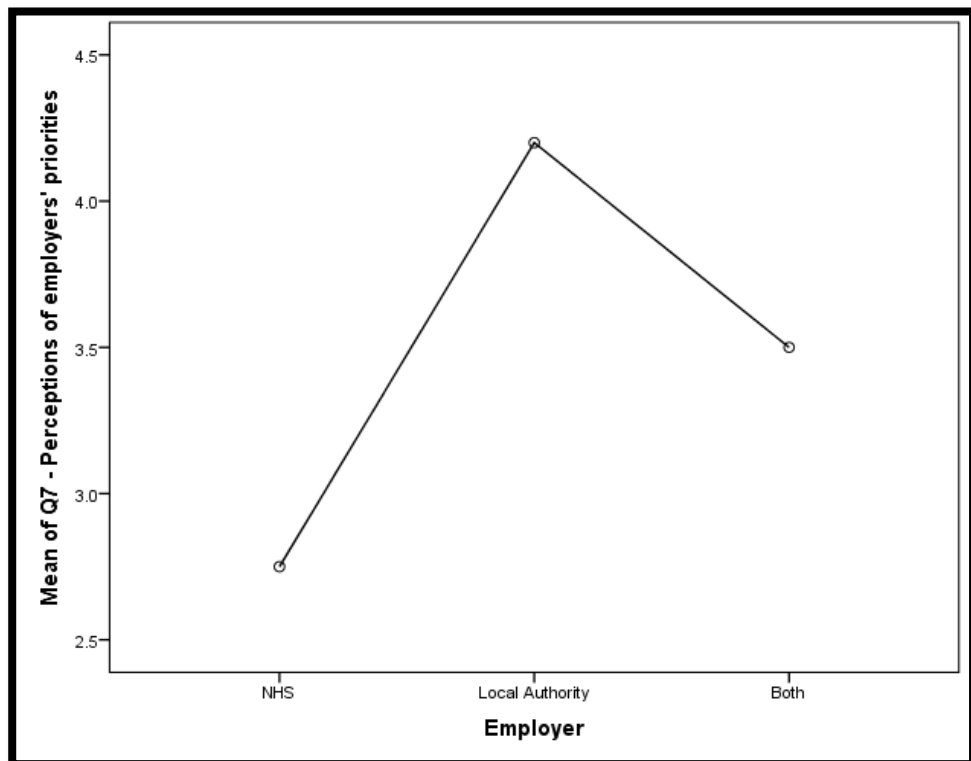
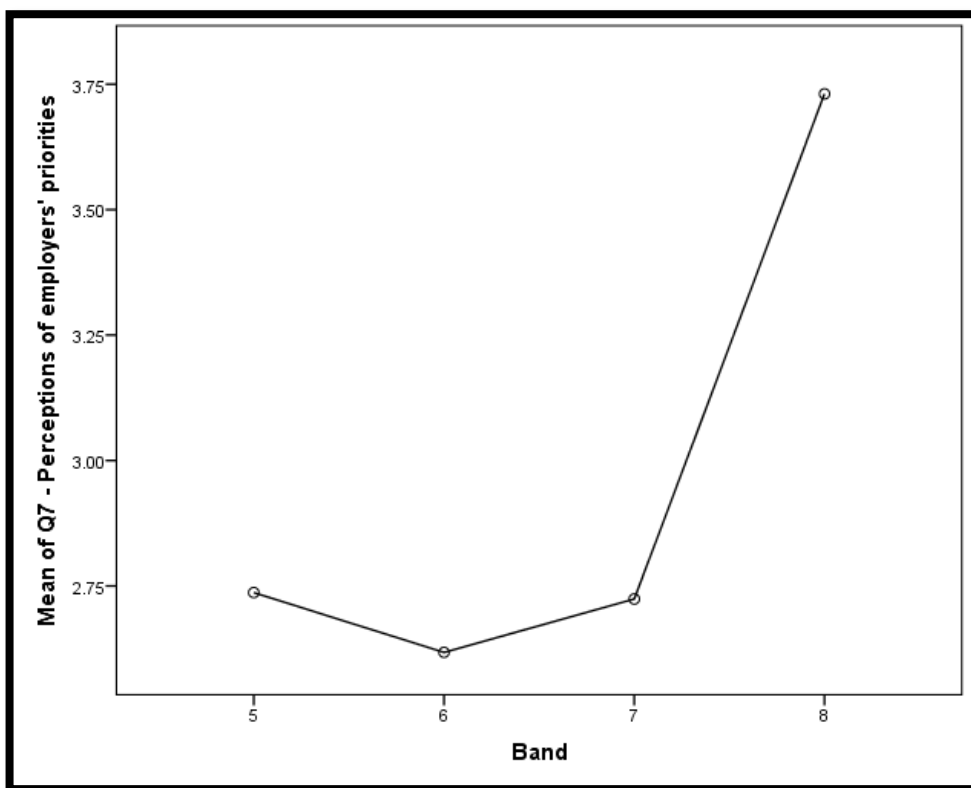
Figure 9l: Band 8 nurses' involvement with public health.



### 9.11 Perceptions of employer's priorities (*My employer prioritises access to public health services by people with learning disabilities*).

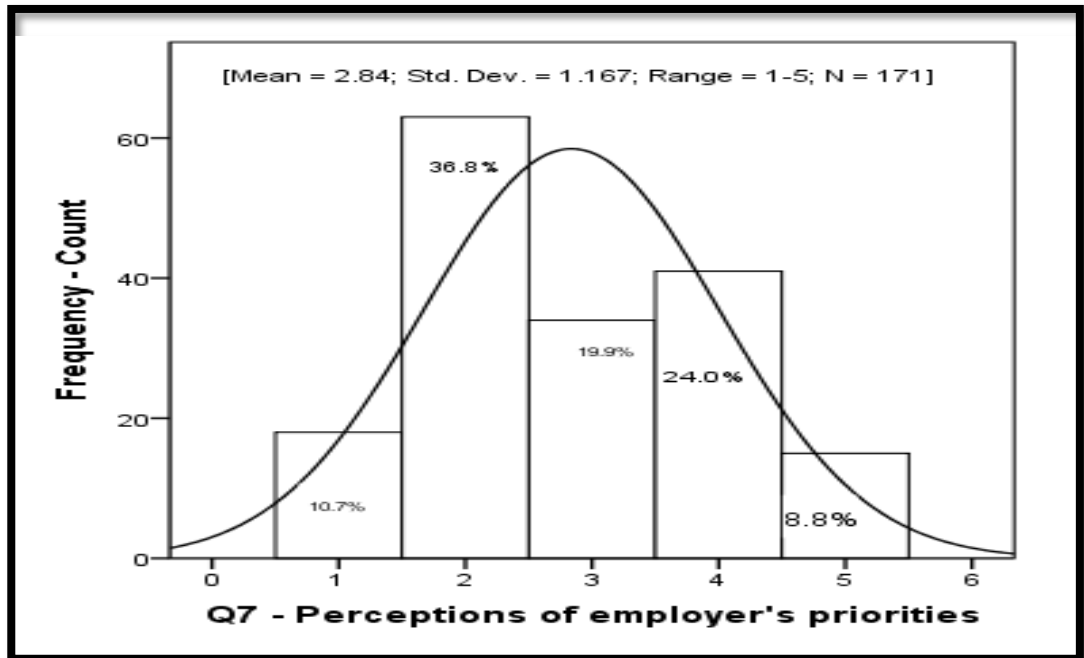
9.11.1 The means plots show that the mean scores for the band, as measured against perceptions of employers' priorities were negatively significant. The plots show that the mean score for band 8 nurses was significantly higher than those for all the other groups (see *Figure 9m*). On the other hand the mean scores for the perceptions of employer's priorities as measured against type of employer suggested that it was highest for nurses employed by local authorities, followed by that of nurses employed in joint appointments. However, this has to be viewed in the context of small numbers of nurses who work in local authorities, and those with joint appointments.

Figure 9m: Perceptions of employer's priorities means plots.



9.11.2 *Figure 9m1* demonstrates a relatively even distribution of participant's responses (Mean = 2.84; Std. Dev. = 1.167; Range = 1-5;  $n = 171$ ).

*Figure 9m1: Distribution of scores for Q7 – 'perceptions of employer's priorities'.*

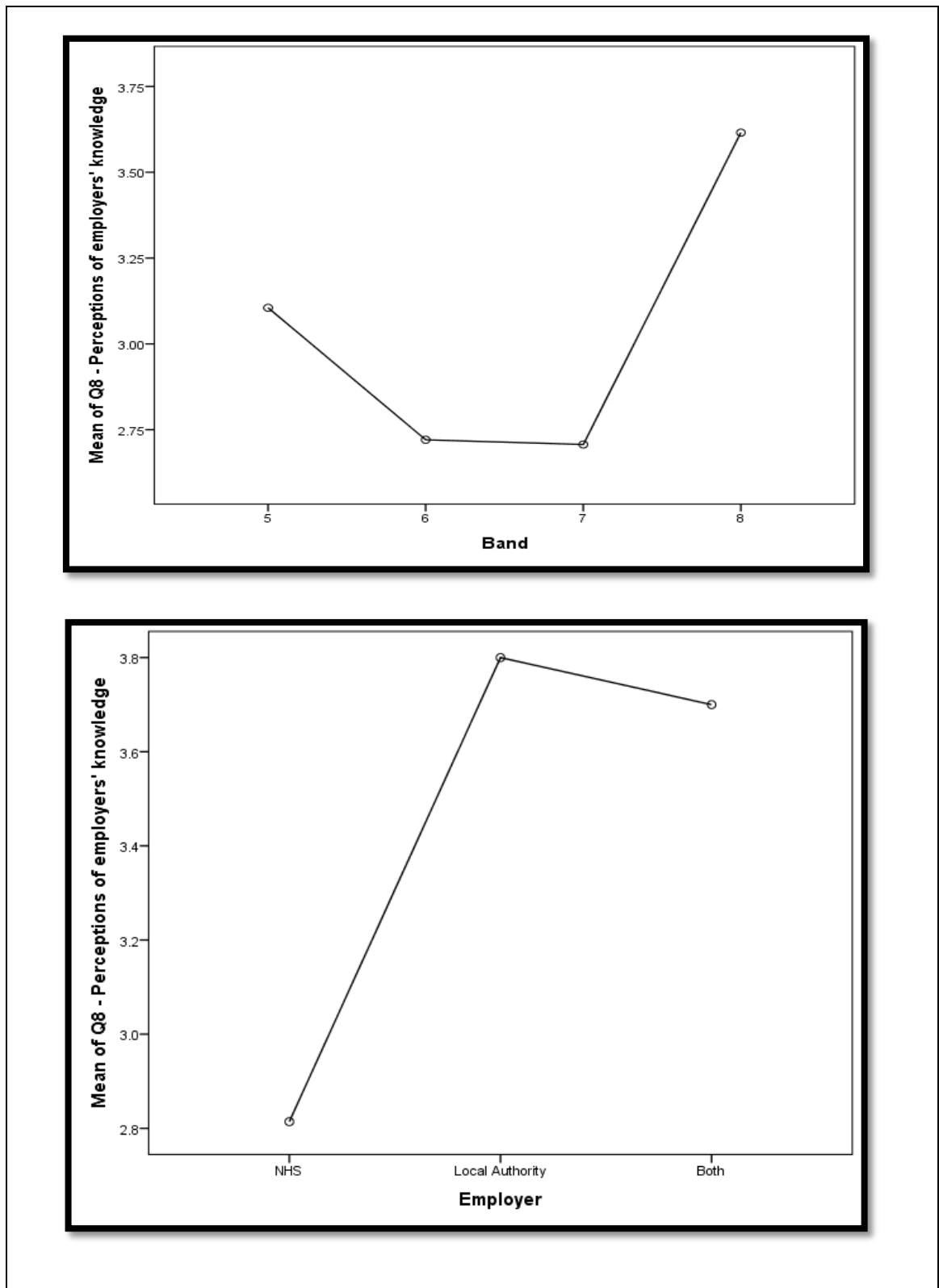


## 9.12 Perceptions of employer's knowledge (*Senior managers in my organisation know about priority areas of public health for people with learning disabilities*).

9.12.1 The mean plots show that the mean scores for the type of employer, as measured against perceptions of employers' priorities were significant. The plots show that the mean score for band 8 nurses at 3.60. This was significantly higher than those for all the other groups (see *Figure 9n*). On the other hand the mean score for the perceptions of employer's knowledge as measured against type of employer suggested that it was highest at 3.8 for nurses employed by local authorities, followed by that of nurses

employed with joint appointments. However, this has to be viewed in the context of small numbers of nurses who work in local authorities and those with joint appointments.

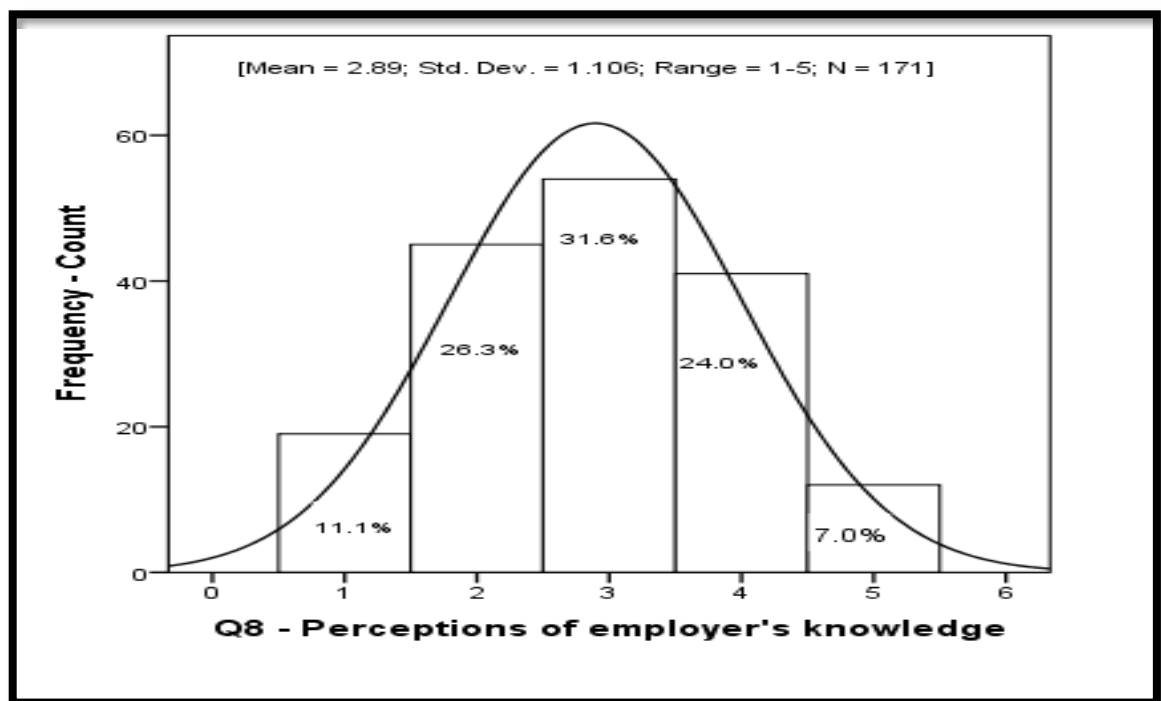
Figure 9n: Perceptions of employer's knowledge means plots.



9.12.2 Figure 9n1 demonstrates a relative even distribution of scores (Mean = 2.89; Std. Dev. = 1.106; Range = 1-5;  $n = 171$ ). Of significance here is

62.6% of participants who were not sure, disagreed, or strongly disagreed that senior managers in their organisations knew the priority areas of public health for people with learning disabilities.

*Figure 9n1: Distribution of scores for Q8 – ‘perceptions of employer’s knowledge’.*



### 9.13 Summary of findings

9.13.1 Of the community learning disability nurses who participated in this study, 90% were employed in NHS organisations, 3% were employed in local authority organisations, and the NHS and local authority organisations jointly employed 7%.

9.13.2 The questionnaire used in the survey was a reliable measure of the moderators of public health role enactment by community learning disability nurses who participated in this study (see Table 9a).

9.13.3 Public health role clarity was highest among band 6 nurses, and lowest among band 8 community learning disability nurses who participated in this study. In addition, role clarity was lowest amongst local authority-employed nurses, and highest among NHS-employed nurses who participated in this study.

9.13.4 Of the community learning disability nurses who participated in this study, positive response rates of public health role review were highest among band 5 nurses and lowest among band 8 nurses. Of the community learning disability nurses who participated in this study positive response rates of public health role review were highest among those employed in NHS organisations and lowest among those employed in local authority organisations.

9.13.5 Of the community learning disability nurses who participated in this study, band 6 nurses reported the highest consistency rates between role expectations and daily role enactment, and band 8 nurses reported the lowest rates. Of the community learning disability nurses who participated in this study, those employed in NHS organisations reported the highest consistency rates between role expectations and daily role enactment, and those jointly employed by NHS organisations and local authority organisations reported the lowest rates.

9.13.6 Of the community learning disability nurses who participated in this study, 95.3% agreed or strongly agreed that they should have a key role in



implementing public health policies for people with learning disabilities.  
1.2% disagreed or strongly disagreed and the rest were not sure.

9.13.7 Of the community learning disability nurses who participated in this study, 57.3% strongly agreed and 36.8% agreed that implementing public health policies for people with learning disabilities was an important role for community learning disability nurses. 1.2% disagreed or strongly disagreed and 4.7% were not sure.

9.13.8 Of the community learning disability nurses who participated in this study, band 8 nurses reported the lowest rates of agreeableness with their perceptions of how organisations prioritised meeting the public health needs of people with learning disabilities and band 6 nurses reported the highest rates. Of the community learning disability nurses who participated in this study, nurses employed in local authority organisations reported the lowest rates of agreeableness with their perceptions of how organisations prioritise meeting the public health needs of people with learning disabilities, and nurses employed in NHS organisations reported the highest rates.

9.13.9 Of the community learning disability nurses who participated in this study, band 8 nurses reported the lowest rates of agreeableness with their perceptions of their employing organisations' knowledge of the public health needs of people with learning disabilities and band 7 nurses reported the highest rates. Of the community learning disability nurses who participated in this study, nurses employed in local authority organisations reported the lowest rates of agreeableness with their perceptions of their employing

organisations' knowledge regarding the public health needs of people with learning disabilities, and nurses employed in NHS organisations reported the highest rates.

9.13.10 Among all the community learning disability nurses who participated in this study, facilitating access to health and health services was the most common public health activity, and health surveillance was the least common.

## **9.14 Conclusion and key findings**

9.14.1 In this explanatory phase of the study, data seem to demonstrate that relationships between moderators of role enactment by community learning disability nurses were varied, complex, and extended beyond existing propositions offered by role theory. In addition, community learning disability nurses' band, and the type of employer were also significant factors in how community learning disability nurses enacted their public health roles in implementing public health policies for people with learning disabilities.

9.14.2 It was also clear that among the community learning disability nurses who participated in this study, facilitating access to health and health services was viewed as a key public health role. It was rather surprising that given that demographic ignorance of the population of people with learning disabilities emerged as one of the key themes in stage 2 of this study, health surveillance was the least common public health activity undertaken by the participants in this study.

9.14.3 In this chapter, and in chapters 7 and 8 I have reported my findings which have identified, described, and explained some of the public health role moderators and relationships between some of these moderators on role enactment by community learning disability nurses. In the next, and penultimate section of this thesis I discuss these findings.

### ***Key findings***

**The relationships of the correlates of public health role enactment by community learning disability nurses who participated in this study were complex and extended beyond the current propositions of role theory, and include periodic review of role expectations, role perception, perceived role value, community learning disability nurses' perceptions of employing organisations' priorities, and community learning disability nurses' perceptions employing organisations' knowledge of the public health needs of people with learning disabilities were some of the moderators of role enactment by community learning disability nurses.**

## **SECTION 4: DISCUSSION**

### **Introduction**

In chapter 3 it was noted that the findings from the 3 stages of this study were convergent. Given this convergence it is appropriate that the discussion I undertake here is integrated. In chapter 7 I discussed the rationale for adopting strategies for reporting research results put forward by Chenail (1995). In chapters 10 and 11 I have adopted a theory driven and logical sequencing of themes approach to my discussion (Chenail 1995).

The overarching aim of this study was to generate new knowledge relating to how community learning disability nurses enact their public health roles in the context of role theory.

Chapter 10 focuses on discussing results from all the 3 stages of the study that related to community learning disability nurses' involvement with public health policy. Chapter 11 focuses on discussing moderators of public health role enactment from stages 2 and 3 of the study. Chapter 12 concludes this thesis by highlighting the strengths and weaknesses of the study, implications for community learning disability nursing practice, and recommendation for improvements to learning disability nursing public health practice.

## Chapter 10: Policy Involvement Roles

### Introduction

To begin with, this discussion focuses on community learning disability nurses' expected involvement, and their active involvement with public health policy implementation for people with learning disabilities. This is followed by a discussion on community learning disability nurses' contribution to public health policy dissemination. The third section in this chapter discusses community learning disability nurses' involvement with public health policy development. The last section discusses the role community learning disability nurses in evaluating the impact of public health policies for people with learning disabilities.

### 10.1 Policy involvement

10.1.1 In the exploratory phase of this study, evidence suggested that community learning disability nurses were expected to be involved in the public health policy process in the **decision-making phase, implementation phase and evaluation phase** of the policy cycle. The evidence specifically suggests that community learning disability nurses were involved in **policy development, policy implementation, policy evaluation, and policy re-design**.

10.1.2 The role expectations highlighted in the exploratory, and descriptive phases of this study suggest that community learning disability nurses were involved in stages 2-5 of the policy process (Howlett and Ramesh 2003) (see *Table 1a*). However, there is no evidence to show any involvement in

the agenda-setting phase of the policy cycle. The lack of studies that investigated the involvement of community learning disability nurses in the policy process was quite limiting in my ability to critically evaluate this evidence. However, these findings are consistent with other studies on nursing involvement with health policy (Schrock 1975; Kunaviktikul *et al.* 2010; Fyffe 2009). The scope of the current study did not seek to explain the causes and moderators of this lack of involvement. However, it would not be surprising if the reasons for non-involvement in agenda-setting was a result of perceptions among community learning disability nurses that health policy agenda-setting is political, and therefore beyond the remit of the nursing profession (Clay 1987). This may suggest that there may be a significant disconnect between public health policy agenda setting and public health policy implementation for people with learning disabilities. Furthermore, this is likely to reflect that the UK government adopts a top-down approach to public health policy despite claims by recent successive governments of an evidence-based model approach to policy agenda-setting (Linder and Peters 1987; Tataw 2010). Given the complexity of the health and healthcare needs of people with learning disabilities, the lack of involvement of public health policy implementers and policy recipients in public health policy agenda-setting is likely to raise questions regarding the appropriateness of some of the implementation strategies of these policies and strategies. I am not advocating that any one model would be appropriate, but it would be appropriate that the potential for other models; such as the participatory approach be evaluated for their appropriateness in meeting the public health needs of people with learning disabilities.

10.1.3 Evidence from the exploratory phase of this study suggest that the expected involvement of community learning disability nurses in policy-decision making (policy development) focused on developing implementation strategies in order to meet the needs of local populations rather than on the development of new public health policies. In the descriptive phase of this study there was some evidence to show that some participants contributed to policy development during the consultation phase of the UK policymaking process. However the involvements were not necessarily resultant of defined role expectations. The findings in the current study are somewhat consistent with a large-scale study undertaken in Thailand involving 2121 nurses, and 26 nurse managers, which demonstrated that 21% of the participants had some involvement in developing public health policy (Kunaviktikul *et al.* 2010). As in the current study, some of the involvement resulted from requirements of occupants of particular positions or through optional contribution to direct or indirect policy discussions. The reasons for the limited involvement were beyond the scope of the current study. However, in my view the complexity of the UK policy process is likely to be a significant factor. In addition, the political nature of the UK policy process is likely to contribute to community learning disability nurses' lack of engagement with the policy process. The nurses may also have negative perceptions of policy formulators as a reason for lack of engagement.

10.1.4 Most of the job descriptions and person specifications analysed in the exploratory phase of the current study referred to the need for learning disability nurses to participate in implementing public health policy in meeting the needs of people with learning disabilities. However, the need

for implementing public health policies was not always clear. In the descriptive phase of the study all participants were expected to be involved in some way in implementing health policy for people with learning disabilities, although the public health contributions were not always explicit. In the explanatory phase of this study all participants reported some involvement with implementing public health policy for people with learning disabilities. Evidence from the job descriptions and person specifications analysed show that community learning disability nurses were expected to implement public health policy for people with learning disabilities through health education, health prevention, health promotion, health protection, and health surveillance. In the descriptive and explanatory phases of this study, the involvement of community learning disability nurses with policy implementation fell into seven *a posteriori* theoretical categories of health promotion, health protection, health prevention, health education, healthcare deliver, facilitating healthcare access, and health surveillance. Facilitating healthcare access was the most common approach to implementing public health policy for people with learning disabilities. Health surveillance was the least common. This is quite surprising given that most participants in the descriptive phase of the study reported that demographic ignorance was one of the most common limiting factors on their ability to implement public health policies for people with learning disabilities. The findings from this study regarding the involvement of community learning disability nurses is consistent with the findings from a study by Kunaviktikul *et al.* (2010). What the current study has managed to do is to be more explicit about the public health roles community learning disability nurses



undertake in implementing public health policies for people with learning disabilities.

10.1.5 What emerges from this study is the complex nature of the public health practice of community learning disability nurses in the UK. In addition, the absence of a clear framework for community learning disability nurses' public health roles, and confusion over role expectations contribute to a lack of clarity about how community learning disability nurses should be involved in public health policy implementation for people with learning disabilities. This lack of clarity demonstrates a lack of common purpose, and lack of collaboration between policy formulators, policy implementers, and policy recipients. It could be argued that this lack of collaboration is likely to result in poor translation of public health policies into practice for people with learning disabilities (Fafard 2008). In addition, it could also be argued that this lack of collaboration in implementing public health policy for people with learning disabilities contributes to the ineffectiveness and poor outcomes of these policies (Davis and Mannion 2000; Crinson 2009). This is also likely to contribute to ambiguity in how community learning disability nurses enact their public health roles. Furthermore, this might reflect the inappropriateness of the bureaucratic model of implementing public health policies for people with learning disabilities. On the other hand this could be a result of a lack of clear organisational structures for implementing public health policies for people with learning disabilities (Sabatier and Mazmanian 1979). It is clear from recent reports that there are significant deficits in health policy implementation and healthcare delivery to people with learning disabilities (DRC 2006; Mencap 2007; Michael 2008; Parliamentary Health

and Social Services Ombudsmen 2009; Mencap 2012). While it is beyond the scope of this study to recommend any particular organisational structure or policy implementation model that would enhance the implementation of public health policies for people with learning disabilities by community learning disability nurses, it is essential that learning disability nurses themselves engage in research to evaluate appropriate models such as Hogwood and Gunn (1984), Majone and Wildavsky (1978), (Mazmanian and Sabitier 1983) and Tataw (2010) (see *Table 1a*). In order to improve the effectiveness of public health policy implementation for people with learning disabilities the focus needs to be on approaches and models that enhance the equal participation, and visibility of policy formulators, implementers, and recipients in policy agenda setting, policy design and development, policy implementation and policy evaluation (WHO 2003; Kretzman and McKnight 1993; Penner 1994).

10.1.6 In stage 1 of this study there was evidence to suggest that learning disability nurses were expected to contribute to public health policy evaluation. However, it is not clear how this would contribute to policy re-design. These findings are consistent with those from the study from a study undertaken in Thailand by Kunaviktikul *et al.* (2010). However, in the Thailand study strategic efforts were being made for nurses to engage in policy evaluation research that would contribute to policy re-design. The lack of a strategic direction in relation to community learning disability nurses' involvement with public health policy evaluation is not surprising given that UK health policy is regularly changed without evaluation (McDonnell *et al.* 2006). As a result there are very few studies, which have

evaluated the effectiveness of health policy implementation for people with learning disabilities.

## **10.2 Role clarity**

10.2.1 In chapter 2 the importance of role clarity in job descriptions was highlighted. Results from the exploratory phase of this study show a lack of consistency in job descriptions of the public health policies community learning disability nurses were expected to implement. In addition, the findings show wide inconsistencies in role expectations organisationally and across NHS bands. These findings are concerning, given that according to Taylor (1996) ambiguous role expectations result in poorly delivered healthcare. In the descriptive phase of this study there was evidence to show that there is public health role ambiguity among community learning disability nurses themselves. In the explanatory phase of this study there was evidence to show that employers and managers of community learning disability nurses had differing public health role expectations for community learning disability nurses. These findings are consistent with studies undertaken in the recent past (Boarder 2002; Hames and Carlson 2006; Mobbs *et al.* 2002; Stewart and Todd 2001). This persistent lack of public health role clarity is rather surprising given that there is long standing evidence to show that clear job descriptions are essential in improving communication, flexibility, and responsiveness at every level of healthcare policy implementation (Taylor 1996). In addition, the findings by Ross (2001), and Fyson (2002) have clearly demonstrated that a lack of role clarity is one of the most significant limitations to successful implementation of health policy. This situation demonstrates a lack of cognisance by

employers and community learning disability nurses themselves of the importance and value of job descriptions in articulating clear role expectations (Levin and Weiss-Gal 2009; Ducey 2002), and role boundaries (Torrington *et al.* 2002).

10.2.2 This lack of role clarity in job descriptions may be reflective of community learning disability nurses' employers' relative values regarding the public health contributions of community learning disability nurses. What might be even more concerning is that the ambiguous job descriptions could be reflective of perceptions of employers' priorities, and how they value community learning disability nurses' contributions (Sidani and Irvine 1999), and perhaps of people with learning disability nurses themselves. It is not being argued that job descriptions reveal the complete picture of community learning disability nurses' public health role expectations, rather that job descriptions validate employers' perceptions of the role value of their staff (Levin and Weiss-Gal 2009).

10.2.3 Another important point that could result from this lack of role clarity is that the boundaries of community learning disability nurses' roles become blurred, confused, and subject to varying interpretations within organisations resulting in further ambiguities. This situation in which community learning disability nurses find themselves in is contrary to best available evidence, which show that clear job descriptions clarify role boundaries for the employer, and for the employees (Marino 2005). It is not difficult to understand that for community learning disability nurses, this is likely to mean that they may be unable to understand the public health

policies they are expected to implement for people with learning disabilities and what public health roles they are expected to play.

10.2.4 What also emerged from analysing job descriptions and person specifications is the amount of references to health policies, which had already been superseded by other policies. Available evidence demonstrates that up-to-date job descriptions are useful in effective role enactment (Grensing-Pophal 2000; Marino 2005). On the other hand, it could be argued that dated job descriptions and person specifications observed in this present study are likely to result in ineffective role enactment. Another important point about UK health and healthcare is the constant reorganisation of health service organisations. Wick (2007) has argued that job descriptions have become indispensable tools for preventing role conflict and chaos in the work environment due to such constant reorganisations. Employing organisations and community learning disability nurses themselves need to ensure that their job descriptions are reviewed in light of emergent public health policies. Reviewing job descriptions to reflect up-to-date policies is important in order to clarify and emphasise new role expectations (Kudless and White 2007). The findings in this present study suggest that there is a need for changes to community learning disability nurses' job descriptions in order to reflect contemporary public health policy initiatives that have currency, and relevance to people with learning disabilities.

10.2.5 The current study took place post-*Agenda for change* (DH 1999c). *Agenda for change* (DH 1999c) intended to standardise role expectations across the

whole NHS. Evidence from this study suggests that this flagship policy had contributed very little to public health role clarity for community learning disability nurses. It has been argued that job evaluations are useful in highlighting the relative value of roles (Werther and Davis 1993), while at the same time making explicit the contributions role incumbents make to organisational objectives (Welbourne and Trevor 2000). Given the relative lack of role clarity in the job descriptions included in this study, it could be argued that *Agenda for change* (DH 1999c) failed to achieve some of the key purposes of job evaluations.

10.2.6 The evidence in this study suggests that job descriptions fail to clarify employers' expectations of roles is consistent with a large-scale study undertaken in the United States of America by Grant (1997). As in the study by Grant (1997), in the current study sources of role ambiguity included inaccurate, vague, and out-dated job descriptions. In stage 3 of the current study a significant proportion of community learning disability nurses reported that their managers failed to ensure that job descriptions were reviewed to ensure role clarity. In the study by Grant (1997) there was evidence to suggest that failure to ensure role clarity in job descriptions was based on managers' assumptions that staff knew what these roles and responsibilities were. However, in this present study there is evidence to suggest that the lack of public health role clarity in job descriptions may result from employers' lack of understanding of the public health needs of people with learning disabilities. In addition, it could be argued that the lack of public health role clarity in community learning disability nurses' job descriptions is reflective of employers' lack of prioritisation of the public

health needs of people with learning disabilities. This in turn could be reflective of the employers' relative values of the contributions community learning disability nurses make to public health policy implementation for people with learning disabilities.

10.2.7 Lack of public health role clarity for community learning disability nurses may contribute to how they perceive their public health roles, and also on how other professionals perceive those roles. How community learning disability nurses perceive their public health roles could impact on how they enact those roles. Failure to ensure public health role clarity on the part of the employers, and community learning disability nurses themselves demonstrates a failure to appreciate available evidence. Evidence from a study undertaken in Taiwan by Wei *et al.* (2011) suggested that nurses who had clearly defined roles, and explicit job descriptions had positive perceptions of their roles and this in turn positively impacted on how they enacted their nursing roles.

10.2.8 In this present study the public health roles of community learning disability nurses could be categorised as healthcare delivery, facilitating healthcare access; health promotion, health protection, health prevention, health surveillance, health education, research, and leadership. Clearly these sets of role expectations are complex and require significant organisation in order for job occupants to effectively enact them. Bollard (2002), Marshall and Moore (2003), and Barr *et al.* (1999) have noted that learning disability nurses contributed to public health policy implementation through health facilitation, health promotion, and health education. In the current study

there is evidence to show that community learning disability nurses' public health roles are more complex, and include healthcare delivery, health protection, health prevention, health surveillance, research, and leadership, in addition to the public health roles identified in previous studies. Although this study has highlighted the extent of the involvement of community learning disability nurses in implementing public health policy for people with learning disabilities, the lack of strategic clarity of these roles need to be addressed. This is important because this lack of clarity extends among community learning disability nurses themselves, other public health professionals, employers (Boarder 2002; Hames and Carlson 2006; Mobbs *et al.* 2002; Stewart and Todd 2001). The lack of public health role clarity for community learning disability nurses can only lead to role confusion and ineffective implementation of public health policy for people with learning disabilities (Fyson 2002; Ross 2001). Ensuring strategic public health role clarity of community learning disability nurses' public health roles could result in improved flexibility and improved responsiveness in policy implementation (Taylor 1996). In addition, ensuring public health role clarity is likely to result in improvements on how community learning disability nurses enact their public health roles.

### **10.3 Policy implementation roles**

10.3.1 Evidence in this study show that community learning disability nurses who participated in this study show that they were involved in implementing public health policy for people with learning disabilities through health education, health prevention, health promotion, health protection, health



surveillance, healthcare access facilitation, and healthcare delivery. As noted earlier, facilitating access to health and health services was the most common public health activity and health surveillance is the least common among the nurses who participated in this study. Evidence also show that a wide range of factors moderate community learning disability nurses' involvement with public health policy implementation.

10.3.2 For band 5 participants the most common public health activity was health promotion (95.2%), and health surveillance (57.1%) was the least (see *Figure 9h*). For band 6 nurses, health promotion (100%) and facilitating access to health (100%) were the most prominent, and health surveillance (73.7%) the least (see *Figure 9i*). 96% band 7 participants reported involvement with facilitating access to health and 60% reported involvement with health surveillance (see *Figure 9j*). 94.4% of band 8 participants reported involvement with facilitating access to health, and 44.4% reported involvement with health surveillance (see *Figure 9k*). These findings suggest that the public health role of community learning disability nurses is becoming increasingly facilitatory. One reason for this is likely to be a response to recent policy developments (Scottish Executive 2000b; DH 2001; Department of Health, Social Services and Public Safety 2004). Community learning disability nurses cited demographic ignorance as a significant moderator of public health role enactment. It is unclear why that is. The implications of this are further explored in chapter 12 of this thesis.

10.3.3 There was evidence in the exploratory and descriptive phases of this study to show that community learning disability nurses were expected to be

involved with public health policy at various stages of the policy process. Band 5 community learning disability nurses' roles were within the implementation phase of the policy cycle. Band 6 roles were within the implementation and evaluation phases of the policy cycle. Band 7 nurses' public health roles were within the implementation and evaluation phases of the policy cycle. Band 8 community learning disability nurses' public health roles were within the decision-making, implementation, and evaluation phases of the policy cycle through providing leadership, enabling others, developing services, evaluating policy effectiveness, and contributing to policy development. No previous studies that compared the contributions made by nurses at different grades to public health policy implementation could be located. It is however clear here that the level of involvement is somewhat related to the nurse's band.

10.3.4 *'Implementation'* constituted 30% of public health role expectations for band 5 community learning disability nurses. For bands 6, 7, and 8 nurses, policy *'implementation' roles* constituted 27%, 34% and 0% of their public health roles. Evidence suggests that these roles were varied.

10.3.5 It is clear from these findings that community learning disability nurses are increasingly expected to be involved in implementing public health initiatives for people with learning disabilities. Significant changes in role expectations were noted in the liaison and facilitation roles in implementing public health policies for people with learning disabilities. Although no previous studies have specifically focussed on community learning disability nurses' public health roles, their involvement with implementing public health initiatives

have been previously reported (Meehan *et al.* 1995; Barr *et al.* 1999; Mobbs *et al.* 2002; McConkey *et al.* 2002; Barr 2006). These studies highlighted the health promotion, health screening, health education, advisory and support, and facilitation roles of community learning disability nurses. The increasing involvement with public health policy implementation by community learning disability nurses is likely to be partly driven by the health liaison, health facilitation, and health action planning roles that have developed as a result of recent policies for people with learning disabilities (Scottish Executive 2000a; DH 2001; Department of Health, Social Services and Public Safety 2004). It could also be argued that the development of these roles was enhanced by a response to recent reports that highlighted poor experiences of health and healthcare by people with learning disabilities (Mencap 2007; Michael 2008; Parliamentary Health and Social Services Ombudsmen 2009; Mencap 2012). What is also clear in this present study is the increasing visibility of community learning disability nurses in acute settings and in primary care services as a result of their increasing health liaison and health facilitation roles. This observation indicates that there has been a significant shift from the lack of visibility reported in previous studies (Stewart and Todd 2001; Boarder 2002; Mobbs *et al.* 2002; Barr 2004; Hames and Carlson 2006). It is however important to note that the context in which these roles evolved is undergoing fundamental change, and particularly in England, with the proposed transfer of the 'public health' function of the NHS to local authorities. At the same time the re-organisation of the English NHS is seeing learning disability nursing roles being transferred to acute NHS trusts, specialist mental health and learning disability NHS organisations, local authorities, and social

enterprises. All these changes are likely to impact on how community learning disability nurses participate in the implementation of public health initiatives for people with learning disabilities.

10.3.6 The second approach to involvement with public health policy implementation by learning disability nurses identified in this study was through '*facilitation*'. This constituted 19%, 18%, 12%, 0% for bands 5, 6, 7 and 8 respectively. Expectations were varied, and included facilitation of access to primary care services, health screening, health education, and health promotion. In the first context nurses are expected to identify and address barriers to accessing healthcare services through initiatives like DES. In the second context the nurses were expected to facilitate access to health screening through supporting other professionals like practice nurses, GPs, and other primary and secondary care professionals. In the third context the nurses were expected to facilitate the active detection of ill health. In the fourth context the nurses were expected to facilitate health education and health promotion activities.

10.3.7 The '*health facilitation*' role of community learning disability nurses was identified but not adequately described, or explained in previous studies (Barr *et al.* 1999; Bollard 2002; Jukes 2002; Marshall and Moore 2003). Although *Valuing people* (DH 2001) identified health facilitation, there is a lack of clarity regarding professional responsibility for its implementation. What is clear in the current study is the extent and variation of the expected involvement of community learning disability nurses with health facilitation. As with their involvement with '*implementation*', this development seems to

be related to the recent policies for people with learning disabilities (Scottish Executive 2000a; DH 2001; Department of Health, Social Services and Public Safety 2004). What is clear is the increasing acceptance of the importance of the health facilitation role of community learning disability nurses among other professionals within primary and acute healthcare settings. This development has evidently enhanced the public health role of community learning disability nurses. The increasing genericisation of the delivery of healthcare for people with learning disabilities and the shift from treatment to preventative health indicates the need for community learning disability nurses to focus on enhancing their health facilitation knowledge and skills. This change in roles has been noted before (Barr 2006), and is inevitable and unavoidable. It is clear that supporting people with learning disabilities to access public health initiatives is becoming an important public health role for community learning disability nurses.

10.3.8 Previous studies have shown that '*health liaison*' is an important role for community learning disability nurses in the implementation of health policy for people with learning disabilities (Kerr *et al.* 1996; Barr *et al.* 1999; Stewart and Todd. 2001; Powell *et al.* 2004). There is evidence indicating that the health liaison role of learning disability nurses is increasingly being based in acute services (Brown *et al.* 2011). However, findings from this current study reflect a lack of prominence of the health liaison role in the implementation of public health policy for people with learning disabilities. It is quite surprising that there are no references to the public health liaison strategy in the band 6 and 8 nurses' job descriptions and person specifications included in this study. For band 5 nurses this role expectation

only constituted 9%, and 2% for band 7 nurses. In this role, band 5 nurses were expected to liaise with other professionals, families, carers and other agencies in order to support the development of preventative health pathways for people with learning disabilities through health action planning. For band 7 nurses the expectation was for them to liaise with other professionals to improve access to health services for people with learning disabilities. It could be that the health liaison role focused on facilitating access to treatment rather than preventative health.

10.3.9 Barr *et al.* (1999), Mansell and Harris (1998), Stewart and Todd (2001), Bollard (2002), Jukes (2002), Marshall and Moore (2003), and Sowney and Barr (2004) have all emphasised the importance of the '*health promotion*' role of learning disability nurses. In this present study band 5 nurses were expected to undertake health promotion activities in the context of facilitating access to primary care services and working with individuals with learning disabilities. In the second context band 5 nurses were expected to promote health and well being by providing specialist advice and education to people with learning disabilities, their carers, and other professionals. Band 6 community learning disability nurses were expected to engage in promoting health by promoting health and wellbeing, promoting healthy lifestyles, maintaining physical and mental health, promoting access to health service,s and facilitating access to primary health services. For band 7 community learning disability nurses their health promotion role constituted 14% of their expected public health roles. These roles included undertaking individual health promotion work, empowering service users through raising awareness of health issues, developing health profiles,

personal health records, and health action plans. Kerr (2004) has reported on the extent of unrecognised health needs of people with learning disabilities, and these include high morbidity rates of preventable conditions; inadequacy of care experienced by people with learning disabilities; poor access to health and healthcare; and poor uptake of health promotion. Findings from this present study show that the health promotion role of community learning disability nurses extended beyond enabling people with learning disabilities to have control over their health. A study by Fraser (2001) has concluded that it is possible to enable people with learning disabilities regarding their health and healthcare through health promotion. However, the author noted a need for additional supports to be in place. Kerr (1998), Barr *et al.* (1999), and Marshall and Moore (2003) have highlighted the role played by community learning disability nurses in promoting the health of people with learning disabilities through developing personal skills, and facilitating supportive environments for health and healthcare. As the UK health service reorient towards preventative health and health promotion, community learning disability nurses have a key role in the implementation of public health policies for people with learning disabilities.

10.3.10 The importance of the enabling, or '*professional advocacy role*' of the learning disability nurse has been highlighted in existing literature (Gates 1994; Wheeler 2000; Jenkins and Northway 2002; Llewellyn 2005; Llewellyn and Northway 2007). This professional advocacy role is of particular significance because of the individual, organisational, and services systems barriers people with learning disabilities face in accessing

health and healthcare services (Coyle and Northway 1999). For band 6 nurses, this role constituted 9% of their expected public health roles. They were expected;

***‘To enable and empower individuals to access services and actively contribute to decisions which affect the quality of their lives’***  
(JD6E).

10.3.11 The professional advocacy role comprised 10% and 33% for bands 7 and 8 community learning disability nurses respectively. In this study, professional advocacy role expectations were varied, and included enabling service users to access appropriate services through the provision of information and enabling members of primary care teams by providing support in order to improve access to appropriate preventative health services in a wide range of contexts. These enabling roles are important at the individual level given that international studies have shown poor uptake of public health initiatives in the population of people with learning disabilities (Beange *et al.* 1995; Beange and Bauman 1990; Jacobson *et al.* 1989; Howells 1986; Kerr *et al.* 1996; Stein and Allen 1999; Wilson and Hare 1990; Jones and Kerr 1997; Sullivan *et al.* 2003; Wood and Douglas 2007). In addition, reduced access to health screening and health promotion services (Kerr *et al.* 1996; Whitfield *et al.* 1996) suggest that the professional advocacy role of the community learning disability nurse is pivotal in preventing, and minimising the poor experience of health and healthcare by people with learning disabilities. Furthermore, at the individual level Lennox *et al.* (2000) have noted the need for effective health advocacy from relevant health professionals such as community learning disability



nurses. In the UK, healthcare outcomes are dependent on individuals' ability to seek appropriate services (Kerr *et al.* 2003). Given that studies have shown that people with learning disabilities are dependent on others for their health and healthcare outcomes (Robertson *et al.* 2001; Keywood *et al.* 1999), the significance of the professional advocacy role of the community learning disability nurse cannot be over-emphasised. Recent literature has demonstrated that people with learning disabilities experience unequal access to health services (Kerr 2004; DRC 2006; Iacono and Davis 2003; Janicki *et al.* 2002; Scheepers *et al.* 2005; Mencap 2004; Mencap 2007; Michael 2008). Although the UK government health policy has focused on improving people with learning disabilities' access to generic preventative health services for some considerable time (DH 1992; DH 1995; NHS Executive 1998; DH 2001; DH 2009b; Ruddick 2005), there is a disconnect between this policy and the experience of access to services by people with learning disabilities. The continuing disparities in health for people with learning disabilities suggest that policies alone are not enough. The findings from this study suggest that community learning disability nurses have an important professional advocacy role in mediating the effective implementation of public health policies and strategies (Thornton 1996; Wheeler 2000) for people with learning disabilities.

10.3.12 The findings in this study emphasise the need for community learning disability nurses to embrace a health advocacy role. Kerr *et al.* (1996) have noted that this role is an important one in facilitating access to preventative health in a multi-organisational social care context. Previous studies (Kerr 1998; Powrie 2003) have suggested that learning disability nurses could

make significant contributions to the delivery of preventative health to people with learning disabilities through their health advocacy role. Recent reports of the poor experiences of people with learning disabilities in accessing health and health services emphasises the relevance of community learning disability nurses in how public health is delivered.

10.3.13 Given the extent of the evidence that demonstrate that people with learning disabilities experience health inequalities (Scheepers *et al.* 2005; Melville *et al.* 2006), inequity (Sowney and Barr 2004), and poor access to healthcare (DH 1999b; DH 2001; NPSA 2004; Mencap 2004; DRC 2006; Whitehead 1992), it is rather surprising that the expected role of community learning disability nurses in this area constituted a very small part of their public health roles (band 5 (1%), band 6 (15%), band 7 (16%), and band 8 (0%)). This lack of prominent reference to health inequalities in job descriptions somehow demonstrates a lack of cognisance on the part of the employers of studies that have shown that people with learning disabilities are considered a low priority by healthcare professionals (Aspray *et al.* 1999), and the widespread concerns about the inequalities in health for people with learning disabilities (Janicki 2001; Scheepers *et al.* 2005; WHO 1999). Given the extent of these inequalities, the role of community learning disability nurses in reducing inequalities is therefore an important one. In undertaking this role, band 5 community learning disability nurses were expected to;

*‘...support initiatives in identifying and reducing barriers to healthcare’ (JD5TH).*

On the other hand, band 6 nurses were expected to work with other primary health and social care agencies in order to reduce health inequalities by facilitating access to health services, including public health services. In enacting this role, band 6 nurses were expected to establish partnership working with local primary care services and work in collaboration with various primary care agencies in order to mitigate the impact of health inequalities on people with learning disabilities. For band 7 community learning disability nurses this role entailed providing leadership in enhancing and improving access to generic health services, promoting inclusion in generic public health services, preventing ill health, promoting equality of access, improving the quality of life of people with learning disabilities, and working to reduce the adverse impacts of the circumstances of individuals with learning disabilities. Community learning disability nurses in discharging their public health roles occupy the grey area between health and social care services (Mafuba 2009). In order to be effective in enacting their public health roles, they need to work in partnership and in collaboration with other agencies (Kerr *et al.* 1996; Hunt *et al.* 2001) whose priorities may not necessarily be meeting the public health needs of people with learning disabilities.

10.3.14 For '*effective collaboration*', health action planning, health facilitation, and health liaison is considered an important element in the delivery of health and healthcare to people with learning disabilities (DH 2001). Castledine (2002) has noted that community learning disability nurses could play a significant role in the development of coordinated approaches to delivering health services for people with learning disabilities. In addition, Jukes

(2002) has argued that community learning disability nurses are key in developing appropriate pathways and protocols for access to health and healthcare for people with learning disabilities. In the current study, these roles focused on the development of health action plans, effective systems of liaison, and a learning environment for service users.

10.3.15 The findings from this study show that the involvement of community learning disability nurses with public health policy implementation was also in the context of their '*contribution*' to the work of multi-disciplinary teams in implementing public health policy for people with learning disabilities. These roles were in the context of health action plans, health promotion, health education, facilitating specialist clinics, and broad general health initiatives, health screening, and development of accessible public health information. Band 8 nurses were expected to make significant contributions to initiatives that could contribute to the improvement of health, and health outcomes for people with learning disabilities at local, national, and international levels. However, it is unclear how their '*contribution*' role was to be implemented. The '*contribution*' role of community learning disability nurses is important in that it highlights the importance of inter-professional, and interagency collaboration in implementing public health initiatives for people with learning disabilities.

10.3.16 The variation of the public health roles discussed here demonstrate the intricacies of how the UK public health services are organised, and the challenges which people with learning disabilities face when accessing these services. The health facilitation, and professional advocacy roles of

community learning disability nurses highlight their responsibility to challenge public health services in order to improve accessibility for people with learning disabilities. In addition, community learning disability nurses need to collaborate, and work in partnership with others in order to fulfil these roles (Broughton and Thompson 2000). What is clear from the current study is the need for community learning disability nurses at all levels to work as agents of change. To work effectively as agents of change, community learning disability nurses need to have '*leadership*' skills at all levels. In the current study, community learning disability nurses were expected to assume '*leadership roles*' in implementing preventative health programs, developing appropriate services, planning, and development of shared care with primary and secondary health services. These leadership skills are important in order to influence others, and facilitate collaboration that is essential in developing appropriate public health pathways and implementation of public health policies for people with learning disabilities. The importance of the leadership roles of community learning disability nurses in the development of appropriate services for people with learning disabilities have been highlighted previously (Powell *et al.* 2004).

#### **10.4 Policy dissemination roles**

10.4.1 In this present study community learning disability nurses were expected to be involved with implementing policies specific to facilitating access to health and health services by people with learning disabilities such as DES and QOF, health screening, health facilitation, health action planning, and *Valuing people* (DH 2001). References to expected involvement with the health elements of *Valuing people* (DH 2001) were minimal (7% for band 5

nurses; 3% for band 6 nurses; 0% for band 7 nurses, and only 2 references in band 8 job descriptions) and vague.

10.4.2 Perhaps one of the most important developments in attempts at improving access to preventative health for people with learning disabilities is the *Clinical directed enhanced services* (DES) (BMA and NHS Employers 2012). In the current study, nurses were expected to be involved with DES through providing support to primary care services, facilitating access to services, and facilitating health checks. Community learning disability nurses were expected to facilitate the implementation of DES with respect to;

*‘...annual health checks for people with learning disabilities known to local authority’* (JD7BD), and,

*‘Advise and support primary care in their implementation and evaluation of the local and Direct Enhanced Services for people with learning disabilities’* (JD7SY).

10.4.3 Since 2008 additional payments were made available under the GP contract in order to facilitate increased access to health screening for people with learning disabilities. This is recognition of the increased morbidity rates in the population of people with learning disabilities (Backer *et al.* 2009), and experiences of poor access to primary and preventative health services (Melville *et al.* 2006; Lennox *et al.* 1997; Barr *et al.* 1999; Bollard 1999; Webb and Rogers 1999; Curtice *et al.* 2001; NHS Health Scotland 2004). What is surprising in the current study is the limited reflection of community learning disability nurses’ involvement with the

implementation of such an important policy. This is even more surprising given the importance of health screening (Cassidy *et al.* 2002) in facilitating access to healthcare for people with learning disabilities. It is not clear from the current study what the reasons for this could be.

10.4.4 In the current study, health screening was the most, and second most widely cited policy for band 7 (19%) and band 6 (26%) nurses respectively in which community learning disability nurses were expected to be involved. It could be argued that both LES and DES are an acknowledgement of the limited accessibility of health and health services for people with learning disabilities, and these have been advocated for in an attempt to reduce health inequalities (DH 2004a, 2006a; Martin 2003; Alborz 2005). There are limited studies that evaluated the effectiveness of DES or LES. It is however important to point out that there is evidence to demonstrate the benefits and effectiveness of proactive health checks (Barr *et al.* 1999; Martin 2003; Alborz 2005; Baxter *et al.* 2006; McGrath 2010; Emerson and Glover 2010; Robertson *et al.* 2010; Robertson *et al.* 2011; Emerson *et al.* 2011). A review of the implementation of health screening through LES in Portsmouth suggested that awareness and uptake of health screening services for a wide range of conditions significantly improved the health of people with learning disabilities (Bailey *et al.* 2008). In order to implement health screening, community learning disability nurses were expected to;

*‘...work closely with primary care services and multi-disciplinary teams to facilitate health screening checks for people with a learning disability’ (JD7SY).*

The studies referred to here provide evidence that indicate that health screening is an effective approach to identifying unmet health needs, and improving the health and health outcomes for people with learning disabilities. It is also evident that community learning disability nurses need to work with others in order to effectively implement health screening (Cassidy *et al.* 2002; Martin 2003; Alborz 2005; Baxter *et al.* 2006).

10.4.5 Evidence in this study show that community learning disability nurses were expected to '*collaborate*' with primary care services in developing registers for people with learning disabilities. This is an important role for a number of reasons. Firstly, registers are useful in signposting people with learning disabilities to appropriate services (Emerson and McGrother 2010). Secondly, registers highlight the extent of the known, and unknown health needs of the population of people with learning disabilities (Emerson and McGrother 2010). Finally, registers are important in meeting the public health needs of people with learning disabilities (Emerson and McGrother 2010). The need for accurate registers has been previously highlighted (Martin and Martin 2000). In stage 3 of the current study, health surveillance was the least public health role in which community learning disability nurses were involved in across all the four bands under consideration. This is despite concerns raised by participants in stage 2 of the study regarding the extent of demographic ignorance of the population of people with learning disabilities. Demographic ignorance has a significant impact on the implementation of a wide range of public health policies for people with learning disabilities.



10.4.6 Health facilitation was introduced in England as part of the *Valuing people* strategy (DH 2001, 2002). Community learning disability nurses have found themselves as one of the key implementers of this policy. Of all relevant public health policy / strategy references made in stage 1 of the current study, this policy constituted 15%, 29%, 14%, and 0% for bands 5, 6, 7, and 8 respectively. In all references to this policy, community learning disability nurses were expected to assume the health facilitator role. The main purpose of health facilitation is to support access to services (DH 2001, 2002) through direct work with people with learning disabilities, and service development through informing health service planning, and commissioning (DH 2002). Despite the good intentions of this policy initiative recent reports highlight poor access and poor experience of healthcare by people with learning disabilities (DRC 2006; Mencap 2007; Michael 2008; Parliamentary Health Service Ombudsman and Local Government Ombudsman 2009; Mencap 2012). This is despite the publication of *Promoting equality*, which provides more guidance on strategic health facilitation (DH 2007c). In stage 1 of the current study many references were made to the involvement of community learning disability nurses with health facilitation. However, in some cases it was vague as to how the nurses were expected to undertake this role. Jukes (2002) identified empowerment work with individuals with learning disabilities, developing access strategies, policies and procedures, and co-ordination of multi-disciplinary teams as key specialist health facilitation roles. In a review of the health facilitation role in Coventry and Warwickshire, Gaskell and Nightingale (2010) identified health screening, raising awareness of the needs of people with learning disabilities, health surveillance, and development of detailed registers for people with learning

disabilities as the key functions of the health facilitation of community learning disability nurses. In the current study, in undertaking their health facilitation role, community learning disability nurses were expected to;

*‘...be responsible for **implementing.....health facilitation** and health checks for people with a learning disability’ (JD7NS),*

*‘Promote access to health services for people with a Learning Disability through collaboration and partnership working, and the use of health facilitation and health action plans’ (JD6R),*

*‘...help ensure equal access to mainstream Health Services for people with a learning disability by involvement in strategic health planning and **developing health facilitation**’ (JD7LC), and,*

*‘**Develop an appropriate health screening tool** for early identification of health need, liaison with primary healthcare services and the development of support systems required to provide consistent evidence of primary healthcare management of key conditions with recall and follow-up via regular health checks’ (JD6SG).*

What is evident from existing literature is the variation in health facilitation role expectations. What is also evident is that health facilitation needs to be understood and implemented in the context of other policy initiatives such as DES, LES, and health action planning in order for maximum benefits to be realised at the individual and strategic levels. What is also clear is the need for further studies that focus on validating the health facilitation roles of community learning disability nurses.

10.4.7 *Health action plans* (HAPs) were introduced as a part of the *Valuing people* strategy (DH 2001). Like with health facilitation, community learning disability nurses have found themselves as key implementers of this policy. The purpose of health action plans is to facilitate the maintenance, and improvement of the health of people with learning disabilities. With the shift towards preventative health in the UK, it could be argued that the introduction of HAPs, and health action planning was an important development in government attempts to meet the public health needs of people with learning disabilities. The UK government acknowledged a lack of progress in the implementation of the health-related targets for *Valuing people* (DH 2009b). In addition, the absence of any empirical studies that evaluated the impact of HAPs, and health action planning is rather disappointing. Existing research focus on describing the designs of HAPs and health facilitation (Lindsey 2002; Gates 2003; Matthews 2003; Howatson 2005). In the current study, for band 5 community learning disability nurses health action planning constituted 41% of public health policies they were expected to be involved in, 20% for band 6 nurses, 13% for band 7 nurses and 0% for band 8 nurses. What is clear from the current study is the significant expectation that community learning disability nurses would be involved with HAPs, and health action planning. Evidence from the job descriptions under consideration indicates a wide range of expectations at the individual and strategic levels. For example band 5 community learning disability nurses were expected to;

*‘Facilitate the public health agenda by providing advice, education and guidance and act as a health facilitator within the health action planning process’* (JD5LPFT).

It could be argued that the above statement highlights the importance of HAPs, health action planning, and health facilitation in implementing public health policies for people with learning disabilities. In addition, another expectation was that band 6 nurses would;

*'...be responsible for.....implementation and evaluation of health action plans'* (JD6E).

This underlines the expected involvement of community learning disability nurses with HAPs, and health action planning at both the individual, and strategic levels in the implementation, and evaluation of the policy. Furthermore, band 7 nurses were expected;

*'To facilitate, provide advice and support...individual health centres and practices in the development and delivery of health action plans'* (JD7H2).

10.4.8 Although the evidence from the current study demonstrate that community learning disability nurses were expected to play a significant role in the implementation of HAPs, and health action planning, what the study has not addressed is the experience of community learning disability nurses in the implementation of this policy. Given that the UK government has acknowledged the limited progress made in the implementation of public health strategies for people with learning disabilities, it would be useful to investigate how the expectations in job descriptions are translated into practice. This would not only highlight how expectations in job descriptions are perceived by community learning disability nurses themselves, but may indicate how these expectations are translated into actual roles. This would not only have implications for implementation of HAPs and health facilitation

by community learning disability nurses, but on the implementation of wider public health policies and strategies for people with learning disabilities.

10.4.9 The *national service frameworks* (NSFs), and other public health strategies are intended to demonstrate the government's commitment to addressing health inequalities experienced by users of health services including people with learning disabilities. However, for people with learning disabilities, accessing mainstreamed national strategies has been difficult (Sayce and Owen 2006). The philosophical basis of modern UK health policy has been inclusion, and mainstreaming of all services for people with learning disabilities (Thomas and Atkinson 2011; Ferguson *et al.* 2010). However, people with learning disabilities have greater health needs than the general population (Emerson and Baines 2010), and experience poor access to healthcare (DRC 2006; Michael 2008). Given this situation, it is arguable to expect community learning disability nurses to be involved in facilitating the implementation of the various NSFs, and other national public health strategies for people with learning disabilities in order to reduce inequalities and improve access to health and healthcare. No studies could be located that specifically investigated the involvement of community learning disability nurses with specific NSFs, and other public health strategies. In the current study, no coherent pattern emerged regarding the involvement of community learning disability nurses with the implementation of NSFs, and other public health strategies. NSFs constituted 19%, 10%, 8%, and 0% of references made in bands 5, 6, 7, and 8 job descriptions and person specifications respectively. There is limited clarity with respect to how

community learning disability were expected to be involved in enacting their roles in the implementation of NSFs for people with learning disabilities.

10.4.10 Other references made in job descriptions to public health policies or strategies included diabetes, obesity, sexual health, cardiac diseases, *Equally well*, smoking cessation, and *Healthy lifestyles*. Community learning disability nurses' expected involvement with these strategies lacked clarity with respect to their role(s) in implementing these policies and strategies for people with learning disabilities such as in the following example;

*'Ensure 'achieving good health' for people with learning disabilities in line with national and local health improvement plan, targets i.e. reducing cardiac diseases; obesity and diabetes and smoking cessation etc.'* (JD7BD).

No studies could be located that investigated the extent of the involvement of community learning disability nurses with public health policy. However, all the strategies cited in the job descriptions and person specifications examined are of great significance in meeting the public health needs of people with learning disabilities. It could be argued that the involvement of community learning disability nurses in their implementation is important. This is particularly so given increased morbidity rates for conditions like diabetes and obesity (Kerr *et al.* 1996; Barr *et al.* 1999; Melville *et al.* 2006), the health inequalities (Melville *et al.* 2006), and unequal access to health services (Kerr 2004; DRC 2006; Iacono and Davis 2003; Mencap 2007; Michael 2008) experienced by people with learning disabilities. This lack of clarity of role expectation could be indicative of a lack of prioritisation of the

public health needs of people with learning disabilities by employing organisations. It could also be indicative of a lack of understanding of the health and healthcare needs of people with learning disabilities. Either way, this lack of clarity could only lead to role confusion in how community learning disability nurses enact their public health roles in meeting the public health needs of people with learning disabilities.

10.4.11 References to *Darzi* (3%), and *Healthcare for all* (8%) reports in band 7 learning disability nurses' job descriptions included in the current study, and *Valuing people* (100%) for band 8 nurses indicated that there was some expectation that community learning disability nurses need to have a role in implementing action plans arising from such reports. These reports were not necessarily focussed on public health, and no further discussion is warranted here. However, their reference in some job descriptions and person specifications under consideration in this study indicate the breath, and extent of employers' expectations on how community learning disability nurses implement health initiatives for people with learning disabilities.

## **10.5 Policy development roles**

10.5.1 Overall, very limited references were made in job descriptions and person specifications as to how community learning disability nurses were expected to contribute to the development of public health policy. Band 8 nurses were expected to have a '*development*' role (17%) through developing strategies, research, and evidence-based practices. The nurses were expected to;

*'Develop and contribute to national and international networks aimed at improving the lives and health of people with learning disabilities... Initiate and establish collaborations nationally and internationally to promote research activity to improve healthcare for people with learning disabilities' (JD8L).*

It is unclear how this would contribute to the development of public health policy. On the other hand it could be argued that research, and strategy development could contribute to policy development, although indirectly.

10.5.2 The absence of any studies that investigated the involvement of community learning disability nurses in policy development is likely to be reflective of the complexity of the UK public health policy process. This contradicts recent calls for increased participation of policy recipients, and policy implementers in policy planning, formulation, implementation, and implementation evaluation (WHO 2003; Tataw 2010). It is arguable that for public health policies to be effective, policy implementers need to be meaningfully involved at every level in the policy process (Kretzman and McKnight 1993). The benefits of involving policy implementers such as community learning disability nurses in the development of public health policies have been highlighted in chapter 1 of this thesis. The lack of strategic involvement of community learning disability nurses in the development of public health policy need to be addressed in order to ensure the appropriateness of some of the implementation strategies currently being used in practice.



## 10.6 Policy evaluation roles

**10.6.1** Evidence from stage 1 of this study show that band 8 nurses were expected to be involved in policy evaluation (17%). This suggests that community learning disability nurses were expected to have a role in evaluating the effectiveness of a wide range of policies. These policy evaluation roles included evaluating;

*‘...best practice approaches to health promotion, health education and health screening for people with learning disabilities.....’ (JD8L), and,*

*‘...develop information systems in the performance management of the key measures to identify progress against health service access.....for people with a learning disability’ (JD8NHSL).*

**10.6.2** Previous studies have noted that the evaluation of health policy implementation has been neglected (Hill 2003; O’Toole 2004), and particularly so for people with learning disabilities. The contribution of community learning disability nurses in evaluating public health policy effectiveness is important because it is likely to impact on how they enact their public health roles. It is also likely to impact on how people with learning disabilities experience access to public health services. In addition, community learning disability nurses’ involvement with public health policy evaluation is important, because policy implementers influence the effectiveness of policy (Lipsky 1980; Northway *et al.* 2007).

## 10.7 Conclusion

10.7.1 The lack of public health role clarity in job descriptions and person specifications of community learning disability nurses needs to be addressed in order to make clear their contributions to the implementation of public health policies for people with learning disabilities. Despite the public health role ambiguities highlighted here, there is evidence from this study to show that community learning disability nurses are expected to be involved in the public health policy process in the **decision-making, implementation, and evaluation phases** of the policy cycle by engaging in **policy development, policy implementation, policy evaluation, and policy re-design**.

## Chapter 11: Moderators of Public Health Role Enactment

### Introduction

This chapter discusses the moderators of public health role enactment by community learning disability nurses (see *Figure 11a*). It is important to note that this study took place in a time of significant political change, and significant re-organisation of public health service provision in the UK, and particularly in England. These changes are likely to have altered the moderators and correlates of public health role enactment by community learning disability nurses.

As discussed in chapter 7, this thesis adopts a theory driven and logical sequencing of themes approach to the discussion (Chenail 1995). In discussing moderators of public health role enactment in this chapter, the discussion is structured around the foundational coding families of cause, context, process, and consequence (Glaser 1978).

To begin with the discussion focuses on the **cause families** of the moderators of public health role enactment of community learning disability nurses. This section discusses the influence of role clarity in job descriptions, role review, consistency of role expectations with daily activities, role perception and perceived role value, perceptions of employer's priorities, perceptions of employer's knowledge of the public health needs of people with learning disabilities, public health role expectation, dialogical definitions, demographic ignorance, professional silo mentality, organisational silo mentality, policy formulation and

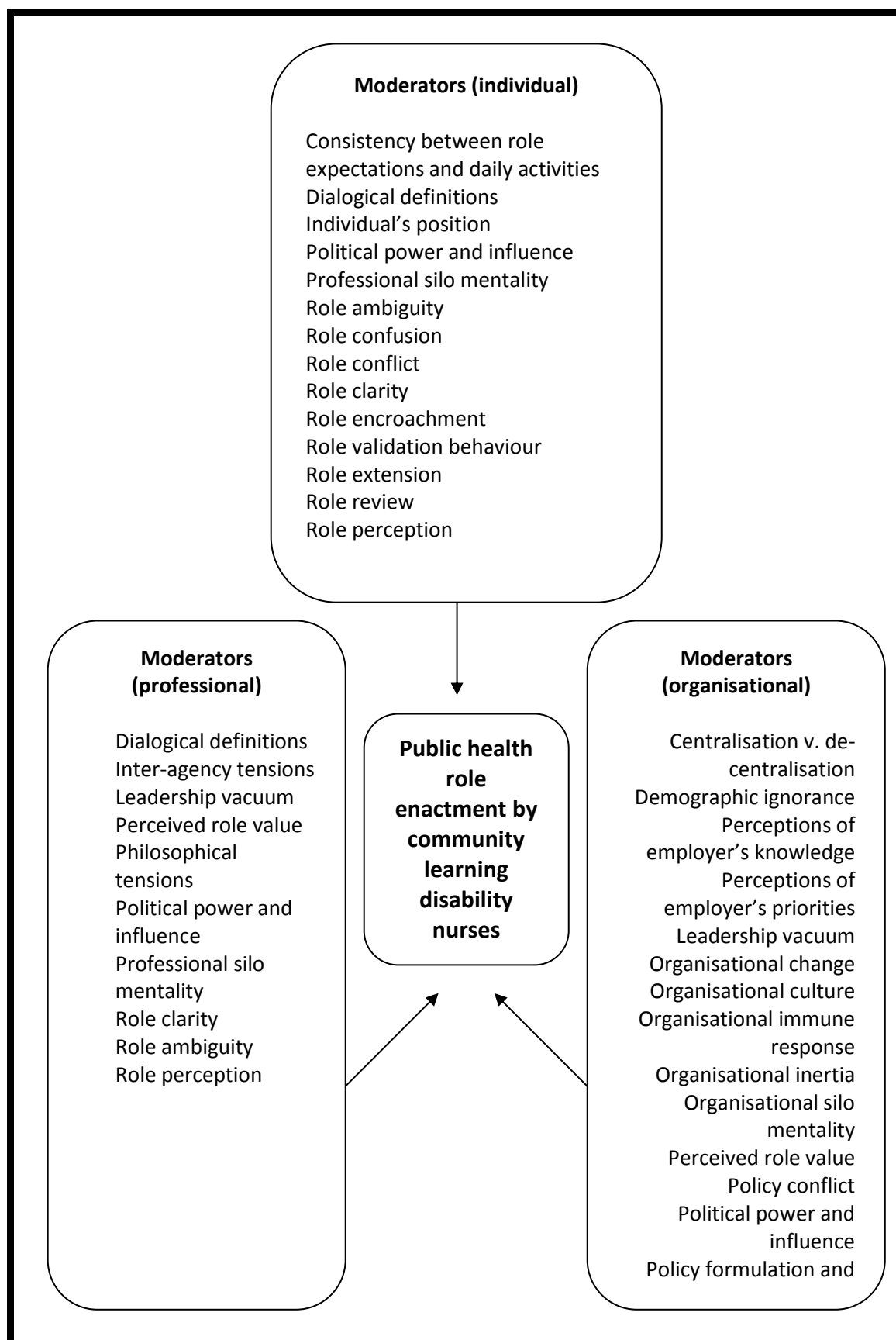
implementation vacuum, and leadership vacuum on how community learning disability nurses enact their public health roles.

The second part of the discussion focuses on the **context families of moderators of** how community learning disability nurses enact their public health roles. Here the discussion focuses on the effect of centralisation *versus* decentralisation to public health policy formulation, and policy implementation in the UK. This is then followed by a discussion of the moderating effects of the political process, and resource constraints on how community learning disability nurses enact their public health roles.

The **process families of the moderators** of public health role enactment by community learning disability nurses are then discussed. In this section the moderating effects of policy conflict, organisational cultures, organisational change, organisational immune response, organisational inertia, inter-agency tensions, philosophical tensions, political power, and political influence on public health role enactment by community learning disability nurses are discussed.

Finally, the **consequence families of moderators** of public health role enactment by community learning disability nurses are discussed. Here the discussion focuses on the moderating effects of inter-agency tensions, role encroachment, role validation behaviour, and role extension on how community learning disability nurses enact their public health roles.

Figure 11a: Moderators of public health role enactment



## ***Cause families of public health role moderators***

### **11.1 Role clarity in job descriptions**

11.1.1 As noted earlier, previous studies have demonstrated that role ambiguity in nursing is related to organisational commitment to the nursing roles involved (Ross and Ross 1981). Evidence from stage 2 of the current study demonstrates that there was public health role ambiguity among community learning disability nurses. Participants in this study indicated that the reasons for this ambiguity are complex. It appears however that the lack of role clarity in job descriptions result in the blurring of role boundaries in practice. The following example illustrates this point;

***'....I don't personally think that managers as they set up learning disability services they give enough thought to the importance of job descriptions and how important they can be in dictating the services' (MDNI17).***

The following example illustrates some of the causes of role ambiguity, and potential consequences;

***'I think the limitations are where we shouldn't be doing other people's jobs....we shouldn't be doing their jobs....we need to be clear about the boundaries of our own roles ...When we were in hospitals we knew what we did. We actually did a lot of social care work and when we went into the community some of us transferred that into the community....So historically we brought that into the community, being all man to everyone..... I***

*know I do things I shouldn't do because there is really no one else to do it' (P5NHS7).*

11.1.2 What is clear here is that role ambiguity may not only lead to role confusion, but that it may lead to role encroachment, role extension, and role validation behaviours (this is discussed later in this chapter). Observations made in this study regarding how community learning disabilities nurses enacted their roles in the presence of role ambiguity are consistent with previous findings (Tunc and Kutanis 2009). What was not apparent from the earlier study referred to here, and which has been observed in the current study are the **concepts of role encroachment, role extension, and role validation behaviour as a consequence of role ambiguity.**

11.1.3 Role clarity in written job descriptions is important (Mafuba 2012a; Wick 2007) in communicating employer's role expectations. In other words, articulate job descriptions are an important foundation for role clarity. Role clarity is an important foundation in how community learning disabilities nurses enact their public health roles. No previous studies have measured the correlates of the moderators of public health role enactment by community learning disabilities nurses. As noted earlier, role clarity significantly moderates how community learning disabilities nurses enact their public health roles.

11.1.4 Evidence from the explanatory phase of the current study demonstrate that **role clarity** among community learning disabilities nurses who participated in the study was **positively correlated to type employer, nurse band**

**(position), role review, nurses' daily activities, perceptions of employers' priorities, and perceptions of employers' knowledge of the public health needs of people with learning disabilities.**

11.1.5 Role clarity in job descriptions is important in how community learning disability nurses enact their public health roles. Of the community learning disabilities nurses who participated in the explanatory phase of this study, 12.9% strongly agreed, and 43.3% agreed that their public health roles were clearly defined in their job descriptions (see *Figure 9b*). What is perhaps of concern is those who were not sure (15.2%), those who disagreed (20.5%), and those who strongly disagreed (8.2%) that their public health roles were clearly defined in their job descriptions. This may mean that 43.9% of the community learning disability nurses who participated in this study were unclear about their public health roles in meeting the public health needs of people with learning disabilities. What is also of concern is a lack of public health role clarity for band 8 community learning disability nurses (Mean = 3.00,  $n = 17$ ) and band 7 (Mean = 2.8,  $n = 53$ ). Significantly less band 8 nurses exclusively worked for the NHS (65%) as compared to 93% (band 7), 97% (band 6), and 100% (band 5). The higher proportion of band 7, and band 8 nurses reporting a lack of public health role clarity in their job descriptions could be a reflection of the fact that some of these nurses were employed by local authorities or had joint appointments. Participants who were employed in local authorities (Mean = 3.6), and those with joint appointments (Mean = 3.4) reported significant public health role ambiguity. It could be that non-NHS agencies do not prioritise the public health needs of people with learning disabilities.



Another reason could be that managers who are non-nurses fail to ensure clarity of community learning disabilities nurses' job descriptions because of their lack of knowledge of the public health roles of the nurses. These findings are consistent with a study by Grant (1997), which reported that staff whose roles were ambiguous reported that their job descriptions were inaccurate, incomplete, and vague.

## 11.2 Role review

11.2.1 In the explanatory phase of this present study there was evidence of a strong positive correlation between role clarity and role review:  $r=.55$ ,  $n = 171$ ,  $p<0.01$  ( $Sig. = .000$ ,  $n = 171$ ,  $p<0.05$ ). What this suggests is that public health roles were clearer among those whose job descriptions were reviewed to reflect current public health policy. *Figure 9c* shows that 70.3% of nurses were not sure, disagreed, or strongly disagreed that their job descriptions were reviewed to reflect current public health policy (Mean = 3.36, Std. Dev. = 1.136, Range = 1 -5,  $n = 171$ ). In addition, band 8 nurses were least in having their public health roles reviewed (Mean = 3.9) and those in local authority employment (Mean = 4.1). It is important to note that role review was influenced by perceptions of employer's priorities:  $r = .41$ ,  $n = 171$ ,  $p<0.01$  ( $Sig. = .000$ ,  $n = 171$ ,  $p<0.05$ ). Furthermore, role review was influenced by the perceptions of employer's knowledge of the public health needs of people with learning disabilities:  $r = .46$ ,  $n = 171$ ,  $p<0.01$  ( $Sig. = .000$ ,  $n = 171$ ,  $p<0.05$ ). What these results show is that the **clarity of the public health role of community learning disability nurses who participated in this study was significantly influenced by role review**. What is also clear here is that **the type of employer influenced role**

**reviews. In addition, role review was influenced by the perceptions of employer's knowledge of the public health needs of people with learning disabilities.** What these findings also show is that **public health role clarity and role review of community learning disability nurses who participated in this study significantly impacted on how they enacted their daily public health roles.** What these results may mean is that community learning disability nurses whose roles are clearly defined are more efficient and more effective in how they implement public health policies for people with learning disabilities.

11.2.2 This study took place post-*Agenda for change* (DH 1999c). At the commencement of the study it was reasonable to expect broad within-bands consistency in public health role expectations for community learning disability nurses. The lack of within-bands consistency in role expectations suggests that the implementation of *Agenda for change* has failed to articulate the variations in role expectations as intended. This implies that the evaluation of community learning disability nurses' public health roles through *Agenda for change* has failed to adequately highlight the importance of these roles (Werther and Davis 1993). In addition, these findings suggest that there has been a failure to articulate the public health contributions of community learning disability nurses (Welbourne and Trevor 2000).

11.2.3 These findings are important because when job roles are clearly defined and mutually understood, role boundaries become clearer (Marino 2005). This in turn is likely to positively moderate how roles are enacted. In

addition, role reviews are important, and as such job descriptions need to be '*living document(s)*' (Grensing-Pophal 2000, p.36). These findings are important because they demonstrate that in order for community learning disabilities nurses to enact their roles effectively, it is vital that job descriptions are accurately maintained (Marino 2005). It could be argued that this is even more important where there are constant policy changes (Kudless and White 2007). In addition, there is real value in ensuring that job descriptions for community learning disabilities nurses are clearly written and up-to-date (Wick 2007). The implication of this is likely to be more effective implementation of public health policies for people with learning disabilities.

### **11.3 Consistency of role expectations with daily activities**

11.3.1 A study by Wick (2007) has concluded that where roles are clearly defined in job descriptions, employees are more likely to be proactive in the effective and efficient enactment of their roles. In the current study, role clarity and community learning disability nurses' daily activities were strongly positively correlated:  $r = .56$ ,  $n = 171$ ,  $p < 0.01$  ( $Sig. = .000$ ,  $n = 171$ ,  $p < 0.05$ ). Overall a significant proportion of participants strongly agreed (13.5%), or agreed (60.8%) that their involvement with public health policy implementation for people with learning disabilities reflected their job descriptions (Mean = 2.37, Std. Dev. = 1.057, Range = 1-5,  $n = 171$ ). However, what is also noticeable here is that 5.8% of participants were not sure, 14.6% disagreed, and 5.3% strongly disagreed that how they enacted their public health roles was consistent with their job descriptions. What also needs to be noted from these findings is the importance of role review in

how community learning disability nurses enacted their daily public health activities:  $r = .32$ ,  $n = 171$ ,  $p < 0.01$  ( $Sig. = .000$ ,  $n = 171$ ,  $p < 0.05$ ).

11.3.2 Although no previous studies which investigated the relationship between the consistency of role expectations and daily occupational activities could be located, it could be argued that these findings are consistent with the findings from a study by Wick (2007). Wick (2007) has noted that where there was role clarity, staffs were more likely to be proactive in efficiently and effectively enacting their expected roles. What might therefore be of concern in the current study is the significant proportion of community learning disability nurse whose daily activities were inconsistent with their role expectations. This is likely to have implications for the implementation of public health policies for people with learning disabilities.

#### **11.4 Role perception and perceived role value**

11.4.1 The public health role of community learning disability nurses was viewed differently by the nurses themselves, other professionals, and by people with learning disabilities as exemplified here;

***‘People see the role in different ways’*** (P1DH1).

11.4.2 A study by Wei *et al.* (2011) concluded that positive role perception was important in role taking and had a positive impact on how nurses enacted their roles. In the current study there was a strong positive correlation ( $r = .62$ ,  $n = 171$ ,  $p < 0.01$  ( $Sig. = .000$ ,  $n = 171$ ,  $p < 0.05$ ) between public health role perception (Mean = 1.37, Std. Dev. = 0.614, Range = 1-5,  $n = 171$ ), and perceived public health role value (Mean = 1.50, Std. Dev. = 0.672,

Range = 1-5,  $n = 171$ ). How public health roles are perceived by community learning disability nurses, and by others, is therefore important and of significance. According to Saha (2008), role perception by employees such as community learning disability nurses is one of the most important moderators of role enactment. Participants in the explanatory phase of the current study indicated that they perceived their public health roles as pivotal, and vital in meeting the public health needs of people with learning disabilities (see *Figures 9n and 9o*). In addition, employers' perception of the public health roles of community learning disability nurses is an important moderator of how these roles are enacted (Levin and Weiss-Gal 2009).

## **11.5 Type of employer**

11.5.1 *Table 9f* shows that role clarity was highest among community learning disability nurses working in the NHS (Mean = 2.60), followed by those on joint appointments (Mean = 3.40), and those in local authority employment (Mean = 3.60). This demonstrates that community learning disability nurses who were in local authority employment were least clear of their public health roles. The reasons and potential implications for this are likely to be complex. These complexities have been discussed widely elsewhere in this thesis and are not discussed further here.

11.5.2 Community learning disability nurses in NHS employment had the highest rates of role reviews (Mean = 3.25), followed by those in joint appointments (Mean = 4.00), and those in local authority employment (Mean = 4.75) (see *Figure 9c*). The low rates of role reviews evident in this study are

concerning. The implications of this are likely to be that community learning disability nurses enact their public health roles based on out-dated role specifications. These results also show that community learning disability nurses in local authority employment were unlikely to have their public health roles reviewed in response to emerging public health policies. The importance of ensuring that job descriptions are regularly reviewed in order to reflect current policies have been highlighted in chapter 2 of this thesis.

11.5.3 Findings in stage 3 of this study show that community learning disability nurses in joint appointments have the least rates of consistency between role expectations and daily public health activities (Mean = 3.75), followed by nurses in local authority employment (Mean = 3.50), and those in NHS employment (Mean = 2.75) (see *Figure 9e*). The high rates of inconsistencies between role expectations and role enactment among community nurses in local authority employment could be that public health activities are not prioritised. Another explanation could be that community learning disability nurses are diverted to engage in non-nursing roles such as care management roles. Whatever the underlying reasons for this phenomenon maybe, community learning disability nurses in local authority employment are likely to be inefficient, and ineffective in implementing public health policies for people with learning disabilities (Wick 2007).

11.5.4 *Figures 9o* and *9p* demonstrate the impact of the type of employer and role perception, and perceived role value respectively. These findings show insignificant differences between the type of employer and the independent variables under consideration. The importance of role perception in role

enactment has been discussed earlier in this chapter, and is not therefore discussed any further here.

11.5.5 Community learning disability nurses in NHS employment had the highest reported rates of prioritisation of their public health roles by their employers (Mean = 2.75), followed by those in joint appointments (Mean = 3.50), and local authority employment (Mean = 4.25) (see *Figure 9l*). This clearly demonstrates a clear lack of prioritisation of the public health roles of community learning disability nurses in a wide range of organisations.

11.5.6 Community learning disability nurses in NHS employment reported the highest rates of perceptions of employers' knowledge of the public health needs of people with learning disabilities (Mean = 2.80) (see *Figure 9m*). Mean scores for nurses in local authority and in joint appointments were 3.80 and 3.70 respectively. These findings are likely to reflect that nurses working in non-NHS organisations are managed by social workers, who are unlikely to understand or appreciate the public health roles of community learning disability nurses.

11.5.7 The findings discussed here demonstrate that the type of employer was a significant moderator of public health role enactment by community learning disability in implementing public health policy for people with learning disabilities. These findings have also consistently shown that this moderating effect is much more significant among community learning disability nurses in local authority employment, followed by those in joint appointments. However, these findings need to be understood in the context of the small numbers of respondents in local authority and joint

appointments. These findings have significant implications. The current model of service provision in which local authorities have agency leadership for service delivery for people with learning disabilities is likely to be contributing to a lack of public health role clarity for community learning disability nurses. This may also be contributing to lack of prioritisation of the public health roles of community learning disability nurses, and consequently on the public health needs of people with learning disabilities.

## **11.6 Perceptions of employer's priorities**

11.6.1 Evidence from the explanatory phase of this study demonstrate that the participants' **perceptions of employer's priorities moderate role clarity**,  $r = .38$ ,  $n = 171$ ,  $p < 0.01$  (*Sig.* = .000,  $n = 171$ ,  $p < 0.05$ ). Evidence also show that perceptions of employers' priorities were correlated to participants' daily public health activities,  $r = .25$ ,  $n = 171$ ,  $p < 0.01$  (*Sig.* = .001,  $n = 171$ ,  $p < 0.05$ ). In addition, participants' **perceptions of employers' knowledge of the public health needs of people with learning disabilities moderate how they prioritise the public health needs of people with learning disabilities**,  $r = .38$ ,  $n = 171$ ,  $p < 0.01$  (*Sig.* = .000,  $n = 171$ ,  $p < 0.05$ ). What is also important to note here is the proportion of participants who reported a lack of prioritisation of the public health needs of people with learning disabilities (19.9% - not sure; 24.0% - disagree, 8.8% - strongly disagree) (see *Figure 9I*).

11.6.2 This is important and is likely to have a significant moderating effect on how community learning disability nurses enacted their public health roles in implementing public health policies for people with learning disabilities. It



appears that the lack of prioritisation of the public health roles of community learning disability is widespread in the NHS, local authorities, and joint teams. This study has not investigated the underlying reasons for this. One explanation could be that employers have to ration limited resources. This would seem a plausible explanation given that there are no ring-fenced resources for meeting the public health needs of people with learning disabilities.

11.6.3 The consequence of this is a lack of prioritisation of the public health roles of community learning disability nurses. This is likely to have significant moderating effects on how community learning disability nurses enact their public health roles. These findings are also likely to be a result of underlying and fundamental philosophical conflicts between community learning disability nurses and their managers (this is explored further later in this chapter).

## **11.7 Perceptions of employer's knowledge of the public health needs of people with learning disabilities**

11.7.1 Results from stage 3 of this study show that how community learning disability nurses' enact their daily public health activities was moderated by perceptions of employers' knowledge of the public health needs of people with learning disabilities,  $r = .35$ ,  $n = 171$ ,  $p < 0.01$  (Sig. = .000,  $n = 171$ ,  $p < 0.05$ ). What is also important to note in these findings was the distribution of participants' responses (see *Figure 9m*). Of significance is the 31.6%, 24.0%, and 7.0% of respondents who were not sure, disagreed, and strongly disagreed respectively that senior managers in their employing

organisations had knowledge of the public health needs of people with learning disabilities.

11.7.2 This perceived lack of knowledge of the public health needs of people with learning disability may result in a lack of prioritisation of the public health roles of community learning disability nurses. This is also likely to contribute to lack of role clarity in the public health roles of community learning disability nurses.

## **11.8 Band**

11.8.1 The Levene's test result was statistically significant (*Sig.* = .341) (see *Table 9b*). The between bands variance was statistically significant (*Sig.* = .006) (see *Table 9c*). Post-hoc comparisons of bands show statistically significant differences between bands (see *Table 9d*). The means plot also demonstrate the differences between the bands (see *Table 9e*). Pearson correlation analysis show a small positive correlation between a nurse's band and the type of employer,  $r = .29$ ,  $n = 171$ ,  $p < 0.01$  (*Sig.* = .000,  $n = 171$ ,  $p < 0.05$ ); and between band and perceptions of employer's priorities,  $r = .24$ ,  $n = 171$ ,  $p < 0.01$  (*Sig.* = .002,  $n = 171$ ,  $p < 0.05$ ). Although these statistics may not appear significant, detailed examination of mean scores revealed some underlying significant issues. Mean scores between band and consistency between role expectations and daily public health activities; band and role perception; and band and perceived role value were largely positive (see *figs. 9n, 9o, 9p*).

11.8.2 Broadly, bands 5, 6, and 7 nurses were positive about the clarity of their public health roles (Mean = 2.70, 2.40, 2.70 respectively. Band 8 nurses (Mean = 3.00) reported that their public health roles were unclear in their job descriptions (see *Figure 9b*). These findings are rather surprising. It would not be unreasonable to assume that because of their experience and seniority, band 8 nurses would be clearer regarding their public health roles. These findings are consistent with the lack of public health role clarity from a study involving nurse consultants by Abbott (2007). Overall, these findings contradict those from a study by Chang and Hancock (2003) that concluded that role ambiguity was more significant among newly qualified nurses than more experienced nurses. What is clear is that the causes of a lack of public health role clarity for community learning disability nurses were complex. One explanation could be that for band 5 nurses, lack of public health role preparation in nurse education may contribute to this lack of clarity, while for more experienced nurses such as band 8 nurses poorly articulated public health job roles may be a significant contributor to role ambiguity (Pryor 2007). Poorly articulated job descriptions for band 8 community learning disability nurses may result from employers' assumptions that because of their experience and leadership positions, the nurses undertake their public health roles without being directed (Grant 1997). Another explanation could be that public health roles of community learning disability nurses are relatively new (DH 2007b), and nurses may be in the process of assimilating these new roles (Smith 2011).

11.8.3 *Figure 9c* shows the mean scores of the relationship between band and role review for bands 5, 6, 7, and 8 (Mean = 3.20, 3.25, 3.30, 3.90 respectively).

These findings demonstrate a significant lack of public health role review across all the bands. No similar studies could be located for comparisons to be made. These findings are however quite surprising given that this study took place soon after the implementation of *Agenda for change* (DH 1999c). What is clear is that the lack of public health role review contradicts best available evidence which advocates for the need for a redefinition of roles in response to practice and policy changes (Philibin *et al.* 2010). The implications of this lack of public health role review for community learning disability nurses could be a lack of appreciation of these roles within organisations (Werther and Davis 1993; Welbourne and Trevor 2000).

11.8.4 Band 5, 6, and 7 nurses were more positive regarding their employer's prioritisation of the public health needs of people with learning disabilities (Mean = 2.75, 1.88, and 2.75 respectively). However, band 8 nurses largely reported that their employers did not prioritise the public health needs of people with learning disabilities (Mean = 3.75). One explanation could be that a significant proportion of band 8 participants (35%,  $n = 9$ ) were either employed in local authorities, or had joint appointments (see *Figure 9a*) (Abbott 2007). Another explanation could be that band 8 nurses were line-managed by non-nurses, or non-learning disability nurses who may not prioritise the public health needs of people with learning disabilities.

11.8.5 Band 5, and band 8 nurses reported that their employers had limited knowledge of the public health needs of people with learning disabilities (Mean = 3.13 and 3.63 respectively) (see *Figure 9m*) while responses from bands 6 and 7 were largely positive (Mean = 2.75 and 2.75 respectively).

For band 5 community learning disability nurses, this phenomenon may result from the fact that their wider roles may involve a wide variety of tasks which may give an impression that their line managers do not prioritise the public health needs of people with learning disabilities (Rungapadiachy *et al.* 2006). For band 8 nurses, this is likely to be consequential of non-nursing line management structures.

## **11.9 Public health role expectations**

11.9.1 *Figures 9q – 9t, and Table 11a* illustrate the public health roles in which participants in the explanatory phase of the current study participated in. These findings demonstrate changes in how community learning disability nurses enact their roles, with an increasing public health role. A previous study identified education, health promotion, and health screening as key areas of public health involvement by community learning disability nurses (Barr 2006). In that study 81.08% of participants were involved with health education, 70.27% with health promotion, and 35.13% with health screening. This compares with 81.4%, 93%, and 58.8% respectively in the current study. No significant change was noted in the involvement of community learning disability nurses with health education, but there were significant increase in community learning disability nurses' involvement in health promotion and health screening activities. What was also significant in the current study was the significant proportion of participants who reported involvement with health prevention and protection (50.0%), and facilitating access to health (94.4%).

11.9.2 Previous studies have noted changes to the role of community learning disability nurses, including increasing involvement with public health in England (Boarder 2002; Mobbs *et al.* 2002). Barr (2006), Barr *et al.* (1999), and McConkey *et al.* (2002) have also noted the increasing involvement of community learning disabilities nurses with health promotion and health screening in Northern Ireland. However, what was not clear from these studies are the drivers for this change in the public health roles of community learning disability nurses. What has been observed in this present study is the influence of recent policy initiatives such as health facilitation and health action planning (Scottish Executive 2000b; DH 2001; Department of Health, Social Services and Public Safety 2004). However, this present study has demonstrated that the moderators of how community learning disability nurses enact their public health roles are much more complex.

*Table 11a:* Public health involvement summary of response rates.

Area of public health	Involvement response rates (%)				
	Band 5	Band 6	Band 7	Band 8	Total
Healthcare delivery	66.7	73.7	62.0	83.3	71.3
Health education	76.2	91.2	86.0	72.2	81.4
Health prevention and protection	71.4	84.2	74.0	50.0	69.9
Facilitating access to health	85.7	100.0	96.0	94.4	<b>94.0</b>
Health promotion	95.2	100.0	88.0	88.9	93.0
<b>Health surveillance</b>	<b>57.1</b>	<b>73.7</b>	<b>60.0</b>	<b>44.4</b>	<b>58.8</b>

11.9.3 This study has shown that on average the most common public health role of community learning disability nurses was facilitating access to services (94%) (see *Table 11a*). Previous studies identified this role (Bollard 2002; Marshall and Moore 2003; Barr *et al.* 1999; Abbott 2007). However, none of these studies quantified community learning disability nurses' involvement with health facilitation. One explanation for this high rate of involvement observed in the current study may be the impact of policy changes noted by previous studies (Boarder 2002; Mobbs *et al.* 2002; Barr 2006). Another explanation could be that the roles of community learning disability nurses are becoming more facilitatory as a result of recent policy initiatives (Scottish Executive 2000b; DH 2001; Department of Health, Social Services and Public Safety 2004).

11.9.4 In the study by Barr (2006), health screening (35.13%) was the least reported area of public health involvement by community learning disability nurses in Northern Ireland. In the current study, at 58.8% health surveillance was the least public health role in which community learning disability nurses who participated in stage 3 of this present study were involved. In stage 2 of the current study, participants cited demographic ignorance as one of the most important moderators of how community learning disability nurses enacted their public health roles. It was not clear why community learning disability were least likely to be involved with health screening / health surveillance than any other area of their public health roles. One explanation could be that health screening is part of the GP contract, and nurses' involvement in this area is only through collaboration with GPs who might not see these activities as a priority.

Another explanation could be that UK health has been target driven in the recent past (Bevan 2006), resulting in people with learning disabilities being part of the national statistics.

11.9.5 Although there was significant evidence of community learning disability nurses' involvement with implementing public health policy for people with learning disabilities in this study, continued lack of public health role clarity is likely to continue to present significant limitations on how community learning disability nurses enact their public health roles in meeting the public health needs of people with learning disabilities (Fyson 2002; Ross 2001). For public health policy to be effectively implemented for people with learning disabilities, community learning disability nurses' public health implementation roles need to be further clarified. This would enable them to be more autonomous and be effective facilitators (Penner 1994).

11.9.6 Another observation that could be made from these findings (see *Figures 9q – 9t*) is the lack of significant difference in community learning disability nurses' involvement in some of the public health activities across all the bands. Of particular significance were the rates of involvement with health surveillance, health prevention, and health protection.

11.9.7 The *National skills framework - Dimension HWB1* clearly outlines public health role expectations for each community learning disability nursing band (DH 2004b) (see *Figures 2b* and *2c*). For example, band 5 community learning disability nurses are expected to predominantly engage in health promotion activities, while band 8 nurses are expected to engage in more preventive work. The findings in stage 3 of this current study demonstrated



a disconnect between the expectations in the *National skills framework*, and the public health roles of community learning disability nurses in practice. What is perhaps of significant concern is the limited levels of engagement by band 8 nurses with health surveillance (44.4%), health prevention and health protection (50.0%). These findings are consistent with a study by Abbott (2007), which noted little involvement by nurse consultant in these roles. These findings are concerning, given that participants in stage 2 of this study highlighted demographic ignorance as one of the most significant moderating factors of how they enact their public health roles. These results raise important questions about the contribution of band 8 community learning disability nurses to meeting the public health needs of people with learning disabilities. The reasons for this are unclear, but they are likely to be complex. What is however clear is the need for an in-depth evaluation of the contribution of band 8 community learning disability nurses in meeting the public health needs of people with learning disabilities. This is important because these nurses are in positions of leadership. Lack of role clarity on their part is likely to impact on public health role enactment by the nurses they manage.

#### **11.10 Dialogical definition**

11.10.1 The findings from the current study highlighted three important issues regarding the dialogical definition of public health. The first concerned the language and terminology used. The second concerned how community learning disability nurses conceptualised and translated public health policy into their practice. The third concerned how the conceptualisation and

translation processes influenced identification of '*public health problems*'.

11.10.2 Evidence from this study showed that a lack of an agreed definition of public health is problematic, for example;

*'...."public health policy" in itself, the words are problematic for people.....' (P9BCC5);*

*'.....there is a lack of clarity about what public health means and public health does mean something different to addressing health inequalities, it is more than that, when I'm reading anything about improving healthcare and learning disability I'm reading about improving access to primary healthcare, I'm reading about health facilities, I'm reading about health screening, I'm reading about acute care liaison and of course that is part of public health' (P11N17);*  
and,

*'I also think that public health to me, and this is not saying that anybody else is wrong, means something different, so to me public health is not just health facilitation or public health screening but I think to a lot of learning disability nurses it is' (P11N17).*

Here it appears that a lack of '*shared knowledge*', and '*shared categorisations*' of public health problems, and public health activities contributed to the ambiguity of the public health role of community learning disability nurses. The illustrations above suggest that for some community learning disability nurses, how public health is conceptualised by themselves, or by their employers may result in the focussing of their public health activities on health facilitation, while others may interpret '*public*

*health*' to mean health screening. The impact of this is likely to be organisational variations in the public health services provided to people with learning disabilities.

11.10.3 It could be argued that the acceptability of a definition of '*public*', moderates the strength of its clarity in both argumentative terms and application. Chapter 1 highlighted the contentiousness of (Dawson and Verweij 2007), and the absence of an agreed definition of what '*public health*' means (Bagott 2011; Kaiser and Mackenbach 2008). According to Macagno and Walton (2008), there is a relationship between the extent to which a definition is agreed and shared knowledge and shared categorisations of reality.

11.10.4 In order to prevent variations in interpretation of what '*public health*' means in practice, Dawson and Verweij (2007) have suggested the need to have some clarity of what public health means. There is therefore a need for unambiguous identification of characteristics of '*public health*' for people with learning disabilities in order for any public health activity not to have legitimisation deficits. The challenge in practice for community learning disability nurses lies in how the boundaries of a '*population*' under consideration are set. This is important, given that;

**'.... *public health affects the entire population....*' (P11N17).**

In the UK, the provision of public health services for people with learning disabilities has been ambiguous despite government efforts to improve access to generic public health services by people with learning disabilities. Consequently;

***‘....learning disability staffs think it's not for them and public health staff think that doesn't include learning disabilities ....’***  
(P11N17).

This suggests that the current multi-agency approach to delivering public health services to people with learning disabilities may be contributing to public health role ambiguity for community learning disability nurses. With the current plans in England to shift public health responsibility to local authorities, it remains unclear what the contribution of community learning disability nurses in meeting the public health needs of people with learning disabilities would be.

### **11.11 Demographic ignorance**

11.11.1 In the UK there is no unified central database of the population of people with learning disabilities. Local registers exist, and as discussed earlier, these are important in highlighting the extent of the known and unknown health needs of the population of people with learning disabilities (Emerson and McGrother 2010). Martin and Martin (2000) have noted the need for developing accurate registers.

11.11.2 In stage 2 of the current study, the lack of updated universal registers was highlighted as one of the most significant moderators of how community learning disability nurses enacted their public health roles. Updated, validated, and accurate registers are vital in the implementation of public health initiatives for people with learning disabilities (Turner and Robinson 2010). The evidence in the current study suggest that even in multi-

disciplinary team contexts, the different professional groups maintain their own registers of people with learning disabilities. This may be contributing to the fact that;

***‘.....the majority of people with learning disabilities are not known to services....’(MDNI17).***

The consequences are then that the unknown individuals are out of reach of community learning disability nurses, and consequently unable to receive support in accessing public health services. Another emerging theme here is that;

***‘.....some of the people that were identified through GPs as having learning disabilities don't actually have them.....’***  
(P7NHSH56).

This situation suggests that the absence of agreed universal criteria for entry onto the learning disability registers add to the lack of clarity of the demographic size of the population of people with learning disabilities. What is clear here is that;

***‘...We are only seeing a small cohort of the known population.....’(P14NHSH3).***

What is also clear here is an acknowledgement by senior nurses of the urgent need to improve the accuracy of the registers of people with learning disabilities as exemplified in the following examples;

***‘There's a fourth area of public health priority for us and it is linked to not knowing the populations,....for me the limitations are about not understanding our population and ....we had people on the***

***learning disability register that the GP didn't know were registered.....'*** (P10NHSCWP7); and,

***'.....I think what we need is a register from cradle to grave.....'***  
(P8NHSG5).

11.11.3 John Grant first highlighted the importance of the relationship between demography and public health in the middle of the seventeenth century (Duffy and Behm 1964). Since then, statistical intelligence regarding a population under consideration has formed the basis of public health practice. Understanding the distribution of the population and morbidity rates of people with learning disabilities is therefore important in order for community learning disability nurses to deliver targeted and appropriate services. The importance of the moderating effect of the accuracy of demographic information on the role of community learning disability nurses cannot be over-emphasised. Up-to-date population data would be useful for a number of reasons. Firstly, demographic intelligence is important in the investigation, and diagnosis of the epidemiological problems that affect people with learning disabilities. In addition, this would be useful in facilitating prioritisation of public health programmes for people with learning disabilities. Furthermore, this would enable better targeting of public health initiatives. Demographic intelligence would also be useful in monitoring and evaluating the impact of public health programmes and strategies in the population of people with learning disabilities. Finally, demographic intelligence is likely to be key in ensuring that UK public health policy programmes and strategies for implementation are evidence-based. Clear

and well-designed programmes and strategies are likely to be better understood by professionals and agencies that are involved in the implementation of public health policies for people with learning disabilities. The work being undertaken by Improving Health and Lives - Learning Disabilities Observatory in England is making significant contributions to the demographic intelligence of the population of people with learning disabilities.

### **11.12 Professional silo mentality**

11.12.1 Generally, public health is inter-professional in nature. Inter-professional working in the delivery of health and public health programmes has been advocated for, for some considerable time (WHO 1999; HDA 2003; Wildridge *et al.* 2004; Dion 2004; Tope and Thomas 2007). The argument for inter-professional working in public health is based on the fact that public health problems are too complex for them to be met by one profession (WHO 1999). What is missing from the literature cited here are highlights of the professional silo mentalities that are likely to impact negatively on how community learning disability nurses enact their public health roles in a multi-disciplinary team context. Evidence from stage 2 of the current study suggested that professional silo mentality moderated how community learning disability nurses enacted their public health roles.

11.12.2 A lack of sensitisation in generic public health practice regarding the complexity of the health and public healthcare needs of people with learning disabilities may moderate how community learning disability nurses enact

their public health roles. This view is summarised in the following comment from a learning disabilities nurse consultant;

*'My biggest challenge...is working with public health consultants.....that is because of the **inability to see people with learning disabilities as anything other than a chronic disease**.....because they are used to working with big chronic diseases in the population. **They can't make that intellectual shift to say that it's not a condition and not a disease and that the condition will result in people having a number of diseases**' (P8NHSG5).*

11.12.3 Another negative influence of professional silo mentality on role enactment by community learning disability nurses may be related to lack of demographic intelligence data sharing as reflected in the following statement;

*'The same issues about how do we know who these people are.....if they're not known to services, we found that quite difficult, **we tried to work with GPs looking at their registers but that didn't always work out**' (P16NHBSB1).*

This point has been discussed earlier in this chapter under demographic ignorance.

### **11.13 Organisational silo mentality**

11.13.1 In addition to inter-professional working, by nature public health policy



implementation is inter-agency (HDA 2003; Tope and Thomas 2007). Wildridge *et al.* (2004) have noted that inter-agency partnership working could be difficult to develop. The consequence of failed inter-agency working is likely to be organisational silo mentality phenomena. In the current study, evidence suggested that organisational boundaries appeared to de-sensitise organisations to the health and public health needs of people with learning disabilities. This de-desensitisation may lead to organisational silo mentalities that may contribute to the difficulties community learning disability nurses may have in enacting their public health roles. As discussed earlier, the main problem appeared to arise from a lack of agency leadership regarding the public health needs of people with learning disabilities. In addition, as one participant observed;

*'You're not always privy **even as a senior clinician, you're not always privy to some of the developments that are going on***  
(P14NHSH3).

Consequently,

*'.....**not everybody sees it as their business....and even in community teams, in my own organisation on the health side, it is still rows about....but that's not for us to do***, (P10NHSCWP7).

It appears that there is a need for all agencies and professionals involved to recognise that meeting the public health needs of people with learning disabilities is;

*'....everybody's business, especially the councils and agencies....**we've all got a responsibility to do it***....' (P10NHSCWP7).

The lack of specific agency responsibility for the public health needs of people with learning disabilities make it organisationally difficult for learning disability nurses to fulfil their public health roles. The findings from the current study are consistent with the study by Zimmerman *et al.* (1996) who observed that role ambiguity among school nurses was influenced by the fact that nurses were jointly employed. However, these findings are contradicted by an earlier study by Acorn (1991), which concluded that inter-agency appointments did not necessarily lead to increased role ambiguity.

#### **11.14 Policy formulation and implementation vacuum**

11.14.1 Deficits and disconnects between health policy and health policy implementation were noted previously (Crinson 2009). Evidence from stage 2 of the current study has shown that lack of appropriate strategies on how public health policies and initiatives were implemented for people with learning disabilities appeared to have significance on how community learning disability enact their public health roles as exemplified below;

***‘.....so the document was launched in 2005 but there was no real implementation process put in place’ (P10NHSCWP7).***

11.14.2 An explanation for this could be that offered by writers on wider policy implementation studies who have argued that the majority of policy failures result from failures in implementation (Rutten *et al.* 2010; Tataw 2010). A second explanation could be that the UK policy process is disjointed with little attention on the evaluation of health policy implementation (Hill 2003;

O'Toole, 2004). Another explanation could be from an observation by Northway *et al.* (2007) who pointed out that translating policy frameworks into operational policies is complex. Public health policy is targeted at the whole population and it could be that implementation strategies fail to consider the needs of people with learning disabilities. In addition, community learning disability nurses largely operate outside generic public health, and their public health contributions may not always be recognised by other professionals. It could also be that due to lack of resources, no effective implementation strategies are put in place to ensure public health policy implementation people with learning disabilities (Lin *et al.* 2004).

### 11.15 Leadership vacuum

11.15.1 Stage 2 of the this study provided evidence that suggested that there was a leadership vacuum in learning disability practice that was likely to negatively impact on how community learning disability nurses enacted their public health roles. There was a realisation among participants that there was a lack of representation of learning disabilities nurses at the public health policy agenda-setting level, and at senior management level in organisations that implement public health policy for people with learning disabilities. The following examples illustrate the importance of the need for community learning disability nurses to be involved in setting the public health agenda;

*'So it's about both really, **it's about devising policy, but also to make sure that practice meets policy, that sort of thing**'*  
(P17NHSNH3).

It is about;

***‘Representation at the top level....fully represented by people who are keen and have a real interest in learning disabilities?’***

(P13NHSL2); and,

***‘... shaping the agendas and the policy’*** (P16NHSB1).

11.15.2 One reason for the leadership vacuum could be the current model of joint community learning disability teams (Bollard 1999), which are hosted within local authorities. The consequence of this is likely to be that senior managers within these organisations are likely not to have learning disability nursing background. Another explanation could be that previously community learning disability nurses had limited involvement with public health policy implementation and the increasing involvement at practice level is not being matched at leadership levels.

11.15.3 Another reason for lack of public health leadership is likely to arise from the difficulties and the complexities of multi-professional, and inter-organisational public health environments in which community learning disability nurses practice (Abbott 2007). Another explanation could be that employers are unclear about the public health contributions community learning disability nurses could make.

11.15.4 In enacting their public health roles, community learning disability nurses find themselves occupying a fine line between health and social care (Mafuba 2009). Strategic leadership in organisations which employ

community learning disability nurses is essential in order for the roles of community learning disability nurses in the implementation of public health policy for people with learning disabilities are to become clearer (Turner and Robinson 2010).

### ***Context families of public health role moderators***

*Figure 8b* illustrates the relationships in the context family of moderators of public health role enactment by community learning disability nurses.

#### **11.16 Centralisation versus decentralisation**

11.16.1 As discussed in chapter 1 of this thesis, the UK health policy process is predominantly bureaucratic (Linder and Peters 1987; Tataw 2010). What this means is that public health agenda setting and policy formulation are politically driven by central government with localisation of implementation. There was evidence from the current study to demonstrate that this approach to public health policy significantly moderated how community learning disability nurses enacted their public health roles. The following quote illustrates this divide between policy formulators, and policy implementers and policy recipients;

*‘I had a phone call from Tony Blair’s office when he was Prime Minister asking us to supply a nurse to go and meet him....then we got another phone call to say, “In that person’s job description, what are they doing in relation to national policy around health?”’ (P16NHSB1).*

11.16.2 What is clear here is that public health policy formulators expected current public health policy to be reflected in community learning disability nurses' job descriptions. What is however not always clear are the systems of cascading public health policies to policy implementers. One of the complexities may arise from the fact that public health policy exists in a wide range of policy and strategy documents. In practice the priorities are not always explicit. Another variable that is likely to be of significance is that public health policy implementation structures for people with learning disabilities are not always clear. What is also important to realise is that in UK public health practice there are always competing national and local priorities as reflected here;

*'....we have national policy and then we have local policy....so it hasn't always been quite clear about national policy around health, and how we break that down into local roles'*  
(P16NHSB1).

11.16.3 This illustrates the complexities that community learning disability nurses face in enacting their public health roles. The centralisation *versus* decentralisation of public health policy process raises a number of issues. One of the issues that may arise is that new policies and initiatives often do not attract resources for their implementation (Hogwood and Gunn 1997). Another problem is that there is likely to be conflicts of interests, and consequently the implementations of public health policy for people with learning disabilities end up being a compromise (Hill 2004). While the deficits of the UK government's bureaucratic approach to public health

policy identified here may impact negatively on how community learning disability nurses enact their public health roles, democratic approaches are likely to be insufficient (Crinson 2009).

### 11.17 Policy process

11.17.1 As noted in chapter 1 of this thesis the absence of an all-encompassing theory of policy formulation and implementation make implementing public health policy for people with learning disabilities difficult. The UK government's top-down approach to public health policy leaves community learning disability nurses with very limited roles in public health policy formulation (Tataw 2010). This limited involvement in agenda setting, policy formulation, and policy implementation was viewed by some of the participants in stage 2 of this study as an impediment to how community learning disability nurses enacted their public health roles in meeting the needs of people with learning disabilities. There was a realisation among some participants that;

*'....it is about being proactive (in)....**shaping the agendas and the policy**' (P16NHSB1); and,*

*'....it's about devising policy, but **also to make sure that practice meets policy, that sort of thing**' (P17NHSNH3).*

11.17.2 It is clear here that some participants considered their involvement in public health agenda setting and policy formulation as being central to enhancing the public health role of community learning disability nurses. What would be required is a complete paradigmatic shift from a

bureaucratic policy process to a participatory approach (Linder and Peters 1987; Tataw 2010).

### **11.18 Resource constraints**

11.18.1 The increasing divergence between public health needs and limited financial and human resources has resulted in implicit rationing of health services in the UK for a considerable time (Hunter 1995; Ham and Coulter 2001; Eichler *et al.* 2004; Greer 2004). While medical advances have resulted in increased life expectancy for people with learning disabilities, increasing complexities of their health needs has resulted in increased demands on healthcare and health prevention. This does not only present political and economic challenges, but likely to impact on how community learning disability nurses enact their public health roles. The following statement illustrates the disconnect between policy intentions and resources available;

***‘Whereas the policy document says there should be 12 health facilitators in NI, there wasn’t the money for that...’***  
(P10NHSCWP7).

11.18.2 This suggests that the public health roles of community learning disability nurses are impacted by resource constraints. Ham and Coulter (2001) have noted that the impact of implicit and explicit rationing of public health services contributes to exclusion of services, which are at the margins of health services. While the UK government promise to meet the health needs of it’s citizens, resource constraints have resulted in abdication of



responsibility through resistance to ring-fencing context specific resources (Hunter 1995). The consequence of this is likely to be that organisations, which employ learning disability nurses, will only focus on the bigger picture. This is likely to impact on how community learning disability nurses enact their public health roles in meeting the public health roles of people with learning disabilities.

### ***Process families of public health role moderators***

*Figure 8c* illustrates the *process* family of moderators of public health role enactment by community learning disability nurses. The influences were organisational, political power and influence, and political conflict.

## **11.19 Organisational culture, change, and inertia**

11.19.1 In the context of this present study, organisational culture is taken to refer to shared meanings of how employees make sense of their roles in the context of their organisations. As discussed in chapter 1 of this thesis, how community learning disability nurses perceive, describe, and conceptualise their public health roles is the basis of how they legitimise those roles (Davies 2002). How roles are perceived, described, and conceptualised determine how roles are enacted. How roles are enacted forms the basis of the culture of an organisation.

11.19.2 The example given below suggest that how health services are organised in the UK could moderate how community learning disability nurses enact their public health roles;

***'It's not just about me and my job, it's about how the whole policy and infrastructure is organised....' (P4NHSC8).***

There is a suggestion here that the cultural practices within organisations in which community learning disability nurses work may impact on how they enact their public health roles. In addition, the multi-agency nature of public health practice, with associated organisational cultural differences is also likely to have a significant moderating effect on how community learning disability nurses enacted their public health roles. The following statement illustrates the importance of a shared understanding of the public health needs of people with learning disabilities;

***'...its about the management of the boards, we call them NHS boards, understanding and having a desire to look at the needs of people with learning disabilities....(P6NHSG5).***

11.19.3 In practice shared meanings are likely to operate at different levels. There is a sense here that differing professional and organisational cultural practices underlie day-to-day role enactment (Davies 2002). In this present study, the extent and significance of organisational culture as a moderating factor of public health role enactment by community learning disability nurses was however unclear. Scott *et al.* (2002) have argued that complex and multi-level organisational culture is inherent in the UK health system. This complexity is likely to impact on how community learning disability nurses enact their public health roles.

11.19.4 Evidence from stage 2 of this present study demonstrates the significance of how organisational changes could negatively impact on how community learning disability nurses enact their public health roles. There was a view that constant re-organisation of the health system moderated how community learning disability nurses enacted their public health roles. For example;

***‘...the other thing that inhibits our ability is the organisational changes’*** (P4NHSCL8).

In addition, there was a suggestion that the public health agenda was not always a priority during organisational change as illustrated in the following example;

***‘....there were issues within the service requiring an attention at the time around service redesign,....there was a need to develop more specialist nursing roles around particular areas....I think those type of things have tended to dominate within the job description without being specific about the actual health promotion role....’***  
(P7NHSH6).

Furthermore, there were also suggestions that the roles of community learning disability nurses may not have been reviewed due to organisational changes as illustrated in the following example;

***‘...my job description was reviewed because of changes to the geographical boundaries’*** (P8NHSG5).

This may mean that public health does not necessarily remain a priority following a review of roles.

11.19.5 In the recent past there has been multiple organisational change agendas in the UK health system. This involved the creation of new structures, organisations, ideology, and roles (Ashburner *et al.* 1996). These changes have had significant moderating effects on how community learning disability nurses enact their public health roles.

11.19.6 '*Change is inevitable*' (Disraeli 1867). However, how change is managed is important. In this present study there was evidence to suggest the existence of organisational inertia within the health system. One participant in this study commented that;

*'....only 40% of acute hospitals are actually making some positive in-roads into the learning disability agenda and given that the Six Lives report was primarily focused on the acute sector, it's still slightly concerning that 18 months on, **only 40% of acute hospitals are dealing with the issues**' (P14NHS3).*

This example illustrates that how health service organisations respond to policy drivers is likely to have a moderating effect on how community learning disability nurses enact their public health roles. The underlying sources for organisational inertia observed here were unclear. However, it is important to note that organisational inertia acts as a barrier to change (Godwin and Allcorn 2008). For community learning disability nurses, while policy changes may imply clarification of their public health roles, organisational inertia may moderate how they assimilate and enact those new roles.

## 11.20 Policy conflict

11.20.1 Evidence from stage 2 of the current study suggests that public health role enactment by community learning disability nurses may be moderated by political priorities. These priorities may conflict with the public health needs of people with learning disabilities. In the UK, local authorities are the lead agencies for the provision of services for people with learning disabilities. The following example illustrates the potential moderating effect of policy differences social services and learning disability nursing may have;

*'We work within a health and social care context...our manager is also a non-nurse, and there is a perception that public health work....to **promote their own health** (people with learning disabilities)...**is not seen as a priority**' (P11N17).*

What this suggests is that community learning disability nurses may be in positions where their managers do not prioritise the public health needs of people with learning disabilities. The implications of this are likely to be that community learning disability nurses may have been directed to engage in non-nursing roles such as care management roles (Cambridge *et al.* 2005; Abbott 2007). This may not only lead to public health role ambiguity and confusion, but may have a significant moderating effect on public health role enactment. Abbott (2007) has noted that social services managed health and social care teams result in professional isolation resulting from lack of a common vision regarding the needs of people with learning disabilities.

## **11.21 Political power and influence**

11.21.1 As discussed above the lead agency's priorities may not be the public health needs of people with learning disabilities. The nature of UK health service policy and policy implementation is that it is very much driven from central government (Ham 2004). The following example demonstrates the moderating effect of political power and political influence on how community learning disability nurses enact their public health roles;

***'So it's the government that dictates what I do really....It is unpredictable and quite challenging' (P1DH1).***

This suggests that political decisions from central government constantly shift the boundaries of how community learning disability nurses enact their public health roles. In addition, local policy drivers and initiatives may also have moderating effect on those roles.

### ***Consequence families of public health role moderators***

*Figure 8d* illustrates the consequence families of moderators of public health role enactment by community learning disability nurses. There were two families (role, tension), which had a moderating effect on how community learning disability nurses enacted their public health roles.

## **11.22 Inter-agency and philosophical tensions**

11.22.1 The multi-professional and inter-agency nature of UK public health practice has been discussed earlier in this thesis. The multi-disciplinary approach to the public health policy process may result in inter-agency and

philosophical tensions for a variety of reasons including philosophical differences. Historically in the UK within learning disability specialist services, for example, learning disability nursing has practised under psychiatry. Psychiatry has historically prioritised psychiatric treatments rather than prevention. The following comment from a participant in stage 2 of this study illustrates this point;

*'There's also an issue about how **learning disability services have historically sat under the offices of psychiatry** of learning disability and doctors and the power that goes along with that, they are interested in mental health and psychiatry....'* (P10NHSCWP7).

11.22.2 Philosophical tensions are inevitable in an inter-professional environment (Bridges *et al.* 2007; Robinson and Cottrell 2005). Participants in stage 2 of this study reported that both philosophical and agency tensions had moderating effects of how community learning disability nurses enacted their public health roles as illustrated in the following statement;

*'I think people were fire fighting and there was a very strong **social services lead in the team who was fairly powerful....'*** (P5NHSH7).

11.22.3 While on the whole inter-professional and inter-agency working may be an appropriate model for implementing public health policy, evidence in this study suggest that this may have resulted in service fragmentation. The following examples illustrate this point;

***‘The major limitation at the moment is around how we are fragmented in terms of approach....’ (P7NHS6); and,***

***‘....I think the interface between general health services and special health services are going to be absolutely critical in the future because it's not an either or’ (P10NHSWP7).***

11.22.4 This fragmentation may result in community learning disability nurses occupying a very fine line between health services and social care services (Mafuba 2009). As illustrated above, this fragmentation is likely to have significant moderating effects on how community learning disability nurses enact their public health roles. This may result in community learning disability nurses assimilating non-nursing roles.

### **11.23 Role encroachment**

11.23.1 Evidence in this study suggests that a lack of public health role clarity where role vacuum exists may result in role encroachment. The example below illustrates that community learning disability nurses in the process of enacting their public health roles may encroach on other professionals’ public health roles;

***‘With health facilitation, sometimes as learning disability nurses or specialist learning disability professionals we feel confident about working with people with learning disabilities that we either take over or we don’t help other people to feel comfortable’ (P17NHSNH3).***



11.23.2 This finding is consistent with findings by Lauzen (1992). In a study involving practitioners in public relations, evidence showed that where manager role vacuum existed, practitioners who possessed management competencies and aspirations were likely to enact and encroach onto the manager role (Lauzen 1992). In the current study, evidence from stage 2 suggests that role encroachment could occur where public health role vacuum existed. While there was no evidence to suggest that community learning disability nurses may encroach onto roles in which they lack competence, there is potential that this may be the case. Another observation that could be made from the above illustration is that role encroachment by community learning disability nurses was likely to be an active and deliberate act on the part of those encroaching on the roles in question. This is also consistent with findings from the study by Lauzen (1992). Closely related to deliberate role encroachment, there appeared to be another phenomenon, **role validation behaviour**.

#### **11.24 Role validation behaviour**

11.24.1 No literature could be located that has previously explained or identified this phenomenon. Evidence from stage 2 of this study suggest that community learning disability nurses who participated in stage 2 of this study may have engaged in '*role validation behaviour*' as a way of role justification. Evidence suggests that this phenomenon could occur in one of three ways. In the first context community learning disability nurses may have engaged in role validation activities by focussing on personal profile development. This may have resulted from their need to enhance their

professional profile among other professionals. This point is illustrated in the following example;

***‘People have become too inward looking’*** (P1DH1).

In the second context community learning disability nurses may have become more interventionist in order to validate their public health and wider nursing roles. In the context of public health policy implementation for people with learning disabilities, the consequence of this may have been negative or positive. The positive perspective is that community learning disability nurses in efforts to validate their roles may have engaged in implementing public health policy. From a negative perspective it may mean that community learning disability nurses engaged in activities that did not enhance the clarity of their public health roles as one participant commented;

*‘...you have people within those services with a range of knowledge, skills and expertise and **sometimes people like doing what they like doing because they like doing it and it might not actually be what we need them to do**’* (P10NHSCWP7).

The third context was closely linked to the first, and is summarised in the following statement;

***‘Specialisation and interventionism is seen as justification of the LD nurse role’*** (P3NHS2G5).

11.24.2 Community learning disability nurses may develop their skills, knowledge, and expertise in order to validate their roles. However, the implications from the illustrations above may be that community learning disability nurses by specialising in a specific area of practice *‘fail to see the bigger*

*public health picture*'. The consequence of this is likely to be a negative moderating effect on their public health role enactment.

## 11.25 Role extension

11.25.1 Evidence from stage 2 of this study suggest that community learning disability nurses may have had their wider roles extended without adequate evaluation of implications of such changes. These role extensions may have resulted from changes, which may, or may not have been integral to their public health or other core nursing roles. The following example illustrates this point;

***'The Trust has also bolted onto my day-to-day job because before I was just in the learning disabilities division doing this work for the LD population but the Trust then needed to have somebody to take a lead for the whole organisation of public health... they bolt things on as you go into your job plan.... (P10NHSCWP7).***

11.25.2 The illustration above may not necessarily reflect role extensions initiated by community learning disability nurses themselves. However, taken together with role validation and role encroachment behaviour discussed earlier in this chapter, this may well be the case. The role extensions observed in this study were previously noted by Mesler (1991). The study by Mesler (1991) concluded that changes to medical practice resulted in role extension and role encroachment in pharmacy practice. As learning disability nurses assimilate new public health roles as a result of policy

changes, role extension, role encroachment, and boundary encroachment (Alaszewski 1977; Eaton and Webb 1979) may occur. The current study did not seek to evaluate the impact of role extension. However, the conclusions made by Mesler (1991) that role extension and boundary extension could potentially impact on others' professional roles are also likely to be relevant in community learning disability nursing practice. As a result of role extension, role encroachment, and boundary encroachment, community learning disability nurses may enact their public health roles in environments where role conflict exists. The consequence of role conflict is likely to be significant moderating effect on how community learning disability nurses enact their public health roles.

## **11.26 Conclusion**

11.26.1 Successful public health role enactment by community learning disability nurses requires appropriate role taking (Higgins 2003). What is clear from this study is that the moderators of public health role enactment by community learning disability nurses are complex.

11.26.2 **The moderators of public health role enactment by community nurses identified in this study include, role ambiguity / clarity in job descriptions or person specification, consistency between role expectations and daily activities, frequency of role review, role perception, perceived role value, role validation behaviours, role extension activities, role encroachment activities, presence / absence of a dialogical definition of public health, demographic ignorance, type of employer, incumbent's position (band), perceptions of**

**employer's priorities, perceptions of employer's knowledge, leadership vacuum, professional ignorance, professional silo mentality, organisational culture, organisational change, organisational inertia, philosophical tensions, inter-agency tensions, organisational silo mentality, resource constraints, public health policy process, public health policy implementation vacuum, national / local policy divide, policy conflict, and political power and influence (see *Figure 11a*).**

## **Chapter 12: Conclusions, strengths, weaknesses, and implications**

### **Introduction**

This chapter concludes this thesis that has focussed on how community learning disability nurses are expected to be involved in public health policy for people with learning disabilities, and in turn how they fulfil those expectations.

To begin with, this study's contribution to role theory in the context of how community learning disability nurses' enacted their public health roles in implementing public health policy for people with learning disabilities is discussed. This is followed by a summary of the strengths of the study. The third section in this chapter highlights weaknesses, and the limitations of this study. The final section of this chapter discusses the implications of the study. This specifically focuses on role expectations for community learning disability nurses and moderators of role enactment by community learning disability nurses in implementing public health policies for people with learning disabilities.

### **12.1 Research's contribution to knowledge**

12.1.1 This study has made a significant contribution to our understanding of the moderators of public health role enactment by community learning disability nurses.

12.1.2 This study has highlighted a lack of consistency in how public health policy is reflected in community learning disability nurses' job descriptions and person specifications. This is important because it potentially significantly impacts on how community learning disability nurses enact their public health roles in implementing public health policies for people with learning disabilities.

12.1.3 Previous studies have predominantly highlighted health promotion, health education, and health facilitation as the key public health roles undertaken by community learning disability nurses. This study has demonstrated that in addition to these roles, community learning disability nurses were involved in health prevention, health protection, health surveillance, public health policy delivery, leadership, public health policy development, and public health policy research. This is important because it does not only demonstrate that community learning disability nurses' public health roles are significantly more extended than previously known, but it also demonstrates that these roles are constantly changing. It is therefore imperative that learning disability nurses and their employers regularly review job descriptions and person specifications in order to reflect emerging public health policies and initiatives.

12.1.4 The basic proposition of role theory is that **communication** (Khan *et al.* 1964), **personal capacities** (Sarbin and Allen 1968), **motivation** (Van de Vliert 1974), and **environmental resources** (Khan and Quinn 1970) moderate role enactment. This study has demonstrated that the moderators of public health role enactment by community nurses include, **role**

**ambiguity / clarity in job descriptions or person specification, consistency between role expectations and daily activities, frequency of role review, role perception, perceived role value, role validation behaviours, role extension activities, role encroachment activities, presence / absence of a dialogical definition of public health, demographic ignorance, type of employer, incumbent's position (band), perceptions of employer's priorities, perceptions of employer's knowledge, leadership vacuum, professional ignorance, professional silo mentality, organisational culture, organisational change, organisational inertia, philosophical tensions, inter-agency tensions, organisational silo mentality, resource constraints, public health policy process, public health policy implementation vacuum, national / local policy divide, policy conflict, and political power and influence.**

This study has demonstrated that these moderators exist at the individual, professional, and organisational levels, and that the interactions between them are complex. This new knowledge has enhanced our understanding of how learning disability nurses enact their public health roles. This is important because it demonstrates that current propositions of role theory are inadequate in explaining the moderators of role enactment in learning disability nursing practice.

12.1.5 The questionnaire developed for this study is a reliable measure of public health role enactment by community learning disability nurses. This means that other researchers could benefit from using this instrument in undertaking further research involving public health role enactment by other nurses in similar roles.



**12.1.6 The study has identified that the correlates of role enactment by community learning disability nurses are complex, and include type of employer, incumbent's position (band), role clarity in job description, frequency of role review, consistency between role expectations and role enactment, role perception, perceptions of employers' priorities, and perceptions of employers' knowledge of the public health needs of people with learning disabilities.** Understanding these correlates is important for both learning disability nurses, and for their employers. This provides opportunities for services to consider how these correlates could be managed in order to enhance how learning disability nurses enact their public health roles in implementing public health policies for people with learning disabilities.

## **12.2 Strengths of the study**

**12.2.1** Perhaps the greatest strength of the study is that it sought to answer important questions related to contemporary learning disability nursing practice. The increasing focus on preventative health interventions in the UK means that this study has been useful in clarifying the public health roles undertaken by community learning disability nurses, and at the same time has identified areas that need improvement in order to enhance the implementation of public health policies for people with learning disabilities.

**12.2.2** Previous studies have focussed on broader learning disability nursing roles. No previous study has been undertaken to investigate how community learning disability nurses enact their public health roles within the context of role theory. It could therefore be argued that this study's contribution to role

theory strengthened and enhanced its potential value to learning disability nursing practice.

12.2.3 No previous studies investigating the roles of community learning disability nurses has involved a **3-stage exploratory sequential multiple method study design involving exploratory, descriptive, and explanatory phases**. Previous studies have explored and produced public health role lists for community learning disability nurses. This study has **explored and described the moderators of role enactment by community learning disability nurses**. In addition, **this study has explained some of the correlates of role enactment by community learning disability nurses** through inferential statistical analysis of survey data. This is a significant contribution, because it demonstrates the need for more in-depth studies into how learning disability nurses enact their wider nursing roles. Such studies are essential in order to make clearer; not only the public health roles of community learning disability nurses, but learning disability nursing roles in general.

12.2.4 Another strength of this study lies in the '*outputs*' generated. To date 4 articles have been published in peer-reviewed journals, and three others are being written. This means that this study has made a contribution to new knowledge that will be accessible to practitioners, policy makers, researchers, and others locally, nationally and internationally.

### 12.3 Weaknesses and limitations of the study

12.3.1 All non-longitudinal studies are limited in that they provide a temporal snapshot in constantly and rapidly changing policy and practice landscapes. Therefore, the findings of this study need to be understood and interpreted in the context of public health services for people with learning disabilities in the UK between 2008 and 2012. It is however important to point out that the results provide a significant opportunity in evaluating the contribution made by community learning disability nurses to the implementation of public health policy for people with learning disabilities. **The results also provide an opportunity to assess the current and future public health roles of community learning disability nurses in a rapidly changing environment.**

12.3.2 Stages 1 and 2 of the study were qualitative and therefore conclusions can only be understood in the context in which the research took place. In addition, in stage 3 of the study the main focus was on achieving representativeness by band rather than variability. Although the use of non-proportional quota sampling was very important in achieving representativeness of the sample, results have to be understood in the context of the participants who took part in the study; and thereby limiting generalizability. However, the survey instrument that has been developed will be useful in obtaining comparable data from randomised samples in the future.

12.3.3 Although the sample size in stage 3 of the study was sufficient for testing the relationships of the correlates of role enactment by community learning

disability nurses, it would not be large enough to allow for generalisation of the results in a broader context. Therefore, although it meets internal validity it would be insufficient for wider external validity.

## **12.4 Implications of the study**

### **12.4.1 Role expectations**

12.4.1.1 While variations in role expectations are to be expected in order to reflect local priorities, the current extent of variations in public health role expectations for community learning disability nurses could only lead to confusion and lack of clarity at local and national levels. This study has demonstrated the need for managers of community learning disability nurses to undertake regular role reviews in order to clarify these roles.

12.4.1.2 Previously, community learning disability nurses were broadly expected to be involved with the policy process in the implementation phase. The learning disability nurse consultant role, and broader developments in learning disability nursing roles has led to the involvement of community learning disability nurses in the decision-making, and evaluation phases of the policy cycle. This development means that community learning disability nurses could, and need to be influential in developing public health policy implementation strategies for people with learning disabilities. In addition, the involvement of community learning disability nurses in the evaluation of public health policy implementation strategies for people with learning disabilities could, and need to lead to significant improvements in people with learning disabilities' experiences of public health services.

12.4.1.3 There is a need for clarification of the broader public health roles for community learning disability nurses. The current information on NHS careers' guidance on the roles of learning disability nurses needs to be urgently reviewed to reflect a public health focus in line with the government agenda.

#### **12.4.2 Moderators of public health role enactment by community learning disability nurses**

12.4.2.1 The current absence of an agreed dialogical definition of '*public health*' needs to be addressed in the context of people with learning disabilities. The continued absence of a working definition will only continue to result in lack of public health role clarity for community learning disability nurses with the resultant, and increasing organisational variations in the implementation of public health policy for people with learning disabilities.

12.4.2.2 Community learning disability nurses need to engage in clarifying their public health roles by developing their knowledge of public health policies, and developing an evidence base that validates their extended public health roles which is essential in implementing public health policies for people with learning disabilities.

12.4.2.3 The current extent of the demographic ignorance of the population of people with learning disabilities contributes to inconsistent implementation of public health policy for people with learning disabilities. There is a need for integration of the current disparate local registers for people with learning disabilities. Current good examples of

this already exist. Community learning disability nurses need to embrace their health surveillance roles in order to ensure a detailed understanding of the extent of the populations of people with learning disabilities in their localities.

12.4.2.4 The absence of a clear leadership structure at local and national levels may result in a leadership vacuum regarding the public health needs of people with learning disabilities. There is a need for a clear leadership structure, which incorporates the learning disability nurse consultant role. The current lack of community learning disability nurses' involvement with public health policy agenda setting and policy formulation need to be addressed in order to ensure appropriateness of public health policy implementation strategies for people with learning disabilities.

12.4.2.5 The public health policy process needs to be participatory in order to ensure that community learning disabilities are engaged at every stage of the process. This is essential in order to ensure that public health policy implementation strategies are appropriate for meeting the public health needs of people with learning disabilities.

12.4.2.6 There is need for a seamless and integrated local-national approach to public health policy implementation for people with learning disabilities. This is necessary to address the current organisational variations in the implementation of public health policy for people with learning

disabilities, and at the same time this will enhance the clarity of the public health role of community learning disability nurses.

- 12.4.2.7 The current lack of strategic organisational responsibility for community learning disability nurses needs to be addressed. Current structures are vulnerable to philosophical and political conflicts between health and social care organisations, could result in lack of prioritisation of community learning disability nurses' public health roles.
- 12.4.2.8 The extent of the health needs of people with learning disabilities, poor accessibility of services, and poor uptake of public health activities necessitate the need for dedicated human and financial resources focused on developing demographic intelligence and pathways to public health services for people with learning disabilities.
- 12.4.2.9 The current structure of the NHS is complex and presents significant challenges for the implementation of public policies for people with learning disabilities by community learning disability nurses. There is a need for the NHS, and other organisations to be aware and be more responsive to the public health needs of people with learning disabilities. In addition, NHS organisations need professional and management structures that can respond to public health policy changes, and prioritise the public health needs of people with learning disabilities. The impact of the on-going re-structuring of the public health system, and the shift of responsibility of agency leadership for the delivery of public health services to local authorities in England will

remain unclear for some considerable time. What is also likely to remain unclear is how community learning disability nurses will contribute to the delivery of public health services for people with learning disabilities after these re-organisations.

12.4.2.10 The current fragmentation of public health services for people with learning disabilities between primary care, and specialist learning disability services leads to unnecessary philosophical and inter-agency tensions.

## **12.5 Conclusion**

12.5.1 This explanatory sequential multiple method study has explored how public health policy was reflected, and articulated in community learning disability nurses' job descriptions, and or person specifications. In the exploratory phase of the study, it was found that the job descriptions and person specifications analysed in this study did not adequately or consistently articulate the public health policies community learning disability nurses are expected to implement for people with learning disabilities. There was also significant ambiguity and inconsistencies in how community learning disability nurses were expected to enact their public health roles in implementing public health policies, and public health initiatives for people with learning disabilities.

12.5.2 This study has demonstrated that there were differences in role expectations organisationally in community learning disability nurses' involvement with public health policy. The public health roles of



community learning disability nurses could be categorised as, academic, health education, health prevention, health promotion, health protection, health surveillance, healthcare access facilitation, healthcare delivery, leadership, and policy development and policy implementation.

12.5.3 The four core policy themes in which community learning disability nurses were expected to enact the public health roles were learning disability health access, public health strategies, policy evaluation and re-design, and 'public' health policy. Community learning disability nurses were expected to be involved in the public health process in the implementation phase, evaluation phase, and decision-making phase of the policy cycle.

12.5.4 In stage 2 of this study it has been described, and hypothesised how community learning disability nurses interpreted and enacted their public health roles. The moderators of public health role enactment by community learning disability nurses could be grouped into four broad families of cause, context, process, and consequence. These moderators existed in the individual, professional, and organisational contexts.

12.5.5 Stage 3 of this study has explained some of the relationships of the moderators of how community learning disability nurses enacted their public health roles in the context of role theory. Moderators and correlates of role enactment by community learning disability nurses are

complex and extend beyond the established theoretical propositions of role theory.

12.5.6 This study has demonstrated that role clarity in job descriptions, periodic review of role expectations, role perception, perceived role value, community learning disability nurses' perceptions of employing organisations' priorities, and community learning disability nurses' perceptions of employing organisations' knowledge of the public health needs of people with learning disabilities were some of the correlates of the moderators of public health role enactment by community learning disability nurses. In addition, community learning disability nurses' band, and the type of employer were also significant factors in how community learning disability nurses enacted their public health roles in implementing public health policies for people with learning disabilities.

12.5.7 Overall, this study has demonstrated that public health role enactment by community learning disability nurses is varied. The study has also demonstrated that the moderators of public health role enactment by community learning disability nurses are complex, and not adequately explained by current role theoretical propositions.

## **12.6 Recommendations**

12.6.1 This study has shown that community learning disability nurses play an important and significant role in the implementation of public health policy for people with learning disabilities. As the shift towards '*upstreaming*' (RCN 2012), and more preventative health in the UK gathers pace, the public

health roles of community learning disability nurses need to be made more explicit in the organisations in which they work. Clarity on how community learning disability nurses will enact their public health roles in the future needs to have a strategic impetus. The following recommendations may enhance public health role clarity for community learning disability nurses, and improve how public health services are delivered to people with learning disabilities:

12.6.1.1 ***Job descriptions.*** Job descriptions of all community learning disability nurses need to be reviewed in order to reflect the public health roles identified in the *National profiles* for community learning disability nurses, and *dimension HWB1* of the NHS *knowledge and skills framework* (DH 2004b). The fragmented nature of current services present challenges on the implementation of this recommendation (**Refer to section 7.8, page 227; point 8.3.5, page 236; section 9.5, page 272; section 9.6, page 274; section 10.2, page 303; section 11.1, page 338; section 11.2, page 341**).

12.6.1.2 ***National survey of community learning disability nursing public health roles.*** It is recommended that a national survey to obtain comparable data from a randomised sample be undertaken. Findings from the survey need to inform national guidance on the public health roles of community learning disability nurses. This is important in order to clarify their '*upstream*' roles necessary in promoting the health of people with learning disabilities. The survey could contribute to the evidence base for current and future roles of community learning disability nurses. This will further clarify the national workforce needs and enhance the work already

undertaken by the Learning Disabilities Nursing Task and Finish Group (Gates 2011) (**Refer to section 12.3, page 391**).

12.6.1.3 ***Explanatory research.*** Current and potential researchers of community learning disability nursing roles should focus on explanatory studies that seek to explain the moderators and correlates of community learning disability nurses' public health roles, rather than continuing to focus on exploring and describing these roles (**Refer to section 12.3, page 391**).

12.6.1.4 ***Evidence base.*** Researchers should seek to enhance and develop the current evidence base of the contribution of community learning disability nurses to public health policy implementation for people with learning disabilities. More specifically, such research needs to identify and evaluate the skill base required for community learning disability nurses to effectively enact their public health roles (**Refer to section 12.3, page 391**).

12.6.1.5 ***Impact of role moderators on public health role enactment by community learning disability nurses.*** Studies that focus on the impact of role moderators identified in this current study on how community learning disability nurses enact their public health roles are essential. Given the current shift towards '*upstreaming*' of nursing practice, such studies need to include learning disability nurses in other areas of practice (**Refer to section 9.11, page 286; section 11.6, page 348; section 11.7, page 349**).

12.6.1.6 ***Impact of role moderators on policy implementation effectiveness.***  
In the current environment of limited resources, consideration need to be

made for studies which evaluate the impact of the role moderators identified in this current study on the effectiveness of community learning disability nurses' involvement in meeting the public and other health needs of people with learning disabilities (**Refer to point 8.9.1, page 257; section 10.3, page 308**).

**12.6.1.7 *Learning disability registers.*** Although registers of people with learning disabilities exist within local authorities, these vary widely, and data collected is inconsistent across services (Emerson and McGrother 2011). Therefore, at national level work is required to develop national standardised local registers. This could be modelled on the current work being undertaken by Improving Health and Lives - Learning Disabilities Observatory, and Special Interest Group (Learning Disabilities Registers) (Emerson and McGrother 2011). At local level work is required by community learning disability nurses and their employers to prioritise the gathering of demographic intelligence regarding local populations of people with learning disabilities. Collaborative work undertaken in Bristol by the Public Health Department in the local authority and local primary care services offers a template of how this work could be taken forward (**Refer to point 8.3.3, page 234; section 11.11, page 360**).

**12.6.1.8 *Impact of role moderators on community learning disability nursing recruitment and retention.*** Gates (2011) has highlighted the challenges faced in recruiting onto pre-registration nursing programmes. In addition, he has noted significant retention challenges of both students and qualified nurses. Studies are needed to evaluate the impact of the role moderators

identified in this current study on recruitment and retention of learning disability nursing students and practising community learning disability nurses (**Refer to section 9.8, page 279; section 9.9, page 281; section 11.4, page 344**).

12.6.1.9 ***Collaborative research centres.*** Current and potential research leaders need to seek to establish collaborative research centres. Such research centres would be able to build appropriate intellectual capacity that is necessary to undertake research of local, national, and international standing. In addition, consideration may then need to be made for strategic alliances with other nursing disciplines and other professions, nationally and internationally in order to enhance research capacity further. Current efforts to establish the *Learning / Intellectual disability academics network* involving learning disability nursing academics in the UK and Ireland require support at national levels. The UK Modernising Learning Disabilities Nursing Review (2012) also provides opportunities for collaborative working to enhance research activities among community learning disability nurses (**Refer to section 2.3, page 60; section 12.3, page 391**).

12.6.1.10 ***Evaluation of pre-registration and post-registration education.***

There is a need for current and potential researchers to evaluate existing pre-, and post-registration curricula to evaluate how the concept of public health is taught, and how community learning disability nurses are prepared for their public health roles. This would be valuable in enhancing our understanding of how current and future community learning disability

nurses need to be prepared for their public health roles (**Refer to point 8.3.2, page 231**).

12.6.1.11 ***Contributions to knowledge of public health.*** Work needs to be undertaken by community learning disability nurses to evaluate and develop their knowledge of public health practice. This is essential in order for them to shift their practice from treatment to preventing ill-health, promoting wellbeing, and protecting the health of people with learning. '*Going upstream: nursing's contribution to public health*' (RCN 2012) is a useful starting point (**Refer to point 8.3.5, page 236; section 9.5, page 272; section 10.2, page 303; section 11.1, page 338**).

12.6.1.12 ***Broader community learning disability nursing roles.*** '*Strengthening the commitment*', the report of the UK Modernising Learning Disabilities Nursing Review (2012) has signposted the future direction of learning disability nursing in order to enhance their practice. Practitioners and employers need to ensure that they collaborate in ensuring that community learning disability nurses enact their public health roles in ways that improve the health and wellbeing of people with learning disabilities (**Refer to point 8.3.19, page 246; section 11.19, pages 373**).

12.6.1.13 ***Learning disability nurse consultant roles.*** The role specifications of learning disability nurse consultants need to reflect the NHS *key skills framework* (DH 2004b). This could enhance their public health contributions at both local and national levels. Consideration needs to be made on how the current *Learning disability nurse consultant network* could provide

leadership at national and local levels. This has potential to enhance professional ***community learning disability nursing leadership*** at local, regional, and national levels (Refer to point 8.3.11, page 240; section 11.15, page 367).

12.6.1.14 ***Pre-registration learning disability and post-registration nurse education.*** Further work is required to produce a comprehensive public health role profile of community learning disability nurses that reflects the current trend of the public health needs of people with learning disabilities. These profiles would provide a national template of the pre- and post-registration education needs of community learning disability nurses. This would enhance the NMC Standards for Pre-registration Nursing (NMC 2010). This would also take forward the recommendations of the RCN's position statement on the role of the learning disability nurse (RCN 2011). This work would also contribute to a standardisation of learning disability nurse education, and is consistent with the future envisioned by the Learning Disabilities Nursing Task and Finish Group (Gates 2011) (Refer to point 8.3.5, page 236; point 11.1.1, page 338; point 11.1.2, page 339).

12.6.1.15 ***National resource.*** Work is required to develop a national online resource that focuses on sharing information and resources that enhance community learning disability nurses' ability to implement national public health and other health improvement initiatives for people with learning disabilities. This resource could also act as a database / repository of existing and on-going research into community learning disability nursing roles and related areas of practice. This could be based on the model of



Improving Health and Lives - Learning Disabilities Observatory, or The Knowledge Network being developed by NHS Education for Scotland (Refer to section 2.3, page 60; section 12.3, page 391).

12.6.1.16 **Public health services.** Work is required to evaluate the evidence base for appropriate models for implementing public health initiatives for people with learning disabilities by community learning disability nurses. The contribution of community learning disability nurses in meeting the public and other healthcare needs of people with learning disabilities in ‘mainstream’ services need to be evaluated. The outcome of such work would be important in guiding commissioning agencies and services by highlighting models of good practice (Refer to point 8.3.10, page 240; section 11.14, p366).

12.6.1.17 **Alliances between community learning disability nurses and other public health professionals.** Community learning disability nurses need to focus on building and enhancing their alliances with other professionals whose roles may have moderating effects on how they enact their public and other nursing roles (Refer to point 8.3.9, page 239; section 11.12, page 363).

12.6.1.18 **Public health policy process.** There is a need for community learning disability nurses to be politically sensitised to the public health policy process. Work is required to develop country- and UK-wide mechanisms for community learning disability nurses to co-ordinate their contributions to public health policy development and evaluation. Existing community

learning disability nurses' networks, and the RCN could provide a platform for such developments (**Refer to points 8.3.15 – 8.3.18, pages 243-246; section 11.20, page 377**).

12.6.1.19 ***Knowledge of the public health needs of people with learning disabilities.*** Community learning disability nurses at all levels need to develop local, regional, and national strategies on how to enhance their knowledge of the public health and other health needs of people with learning disabilities in their organisations, and among other professionals whose roles may have a moderating effect on how community learning disability nurses enact their roles (**Refer to point 8.3.3, page 234; section 11.11, page 360**).

12.6.1.20 ***Impact of public health role enactment on service user experience.*** Descriptive and explanatory studies need to be undertaken to evaluate the impact of community learning disability nurses' public health role enactment on the experience of public health services by people with learning disabilities (**Refer to section 9.7, page 277; section 10.4, page 321**).

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## **APPENDICES**

**Appendix 1a:** Emerging themes – *A priori* literature review

Summary findings of articles relating to the public health role of the learning disability nurse: Emerging Themes.

1. The role of the learning disability nurse is varied, complex and increasingly specialized.
2. Learning disability nurses make a significant contribution to the delivery of public health policy for people with learning disabilities through health promotion and health facilitation.
3. Learning disability nurses are key in facilitating collaboration, multi-disciplinary working and multi-agency working in delivering public health services for people with learning disabilities through supporting primary care staff and education.
4. The public health role of the learning disability nurse needs to be evaluated and validated from service user and professional perspectives.
5. The public health role of the learning disability nurse lacks clarity at various levels:
  - a. Learning disability nurses themselves are not clear of their public health role for people with learning disabilities.
  - b. Other key public health professionals are not clear as to the role and contribution of learning disability nurses in delivering public health services for people with learning disabilities.
  - c. Primary care organisations are not clear of the public health contribution learning disability nurses can make in implementing the public health agenda.

### **Summary findings of articles relating to people with learning disabilities' perceptions and experience of public health.: Emerging Themes.**

1. People with learning disabilities are aware of their health needs.
2. People with learning disabilities can comment on their perceptions and experiences of their health.
3. People with learning disabilities can comment on their perceptions and experience of accessing health services.
4. People with learning disabilities can express their views on the contribution made by professionals regarding their healthcare.
5. There are methodological challenges in obtaining the perceptions and narratives of experiences from people with learning a disability.

### **Characteristics of articles relating to policy implementation for people with learning disabilities.**

1. The importance of organisational structures in influencing policy implementation within and across organisational where policy implementation rests with more than one organisation.
2. Organisational structures enable or hinder personal relationships.
3. The importance of organisational structures in policy implementation.
4. The contribution of learning disability nurses to the implementation of public health policy for people with learning disabilities is not clear and is complicated by the fact that their jobs are generally in the cusp of two organisations (NHS and social services).



**Summary findings of articles relating to methodological issues of conducting perception / experience studies involving people with learning disabilities: Emerging Themes.**

1. Involving people with learning disabilities in research is useful and essential in public health.
2. Focus groups are a useful and appropriate method for involving people with learning disabilities in research in health and healthcare.
3. Focus groups can be used in exploratory, evaluation, longitudinal and other studies involving people with learning disabilities.
4. Using focus groups with people with learning disabilities in research can present methodological and practical challenges.
5. Triangulation is valuable in enhancing the breath and depth of data in research involving people with learning disabilities.

# The public health role of learning disability nurses: a review of the literature

Kay Mafuba explores how learning disability nurses contribute to the implementation of public health policy for people with learning disabilities

## Summary

Kay Mafuba examines the literature on learning disability nurses' role in public health. He identifies methodological shortcomings and highlights gaps in knowledge concerning nurses' implementation of national policy and the experiences of people with learning disabilities in accessing public health services.

## Keywords

Literature review, policy implementation, public health

IN THE UK there is a disparity between the health of people with learning disabilities and that of the general population, and between health care for those with learning disabilities and those without (Kerr 2004). People with learning disabilities experience poor access to health care (Department of Health (DH) 1999a, 2001, 2006a, 2007a, Disability Rights Commission (DRC) 2006) and are known to have much greater health need (NHS Executive 1998, DH 1999b, Cancer Research UK 2008). People with learning disabilities experience unequal access to health services (Kerr 2004, DRC 2006) and inadequate diagnosis of treatable conditions.

Furthermore, they are more likely to die from preventable causes (Hollins *et al* 1998, Mencap 2007, DH 2007a, 2007b). International studies have also shown poor uptake of public health initiatives by people with learning disabilities (Beange *et al* 1995, Beange and Bauman 1990, Jacobson *et al* 1989, Howells 1986, Wilson and Haire 1990, Kerr *et al* 1996, Jones and Kerr 1997, Stein and Allen 1999).

The workforce responsible for ensuring that UK public health policy frameworks are implemented is dispersed across various organisations (Wanless 2004). *Facing the Facts* (DH 1999b) noted confusion and a lack of clarity in relation to responsibilities and roles in health care for people with learning disabilities. This suggests that there is a lack of strategic clarity regarding a public health role for learning disability nurses. This may lead to questions about the learning disability nurse's contribution to public health policy implementation and about how people with learning disabilities access public health services.

In recent years NHS senior officials have outlined a public health role for learning disability nurses in England (DH 2007c) relating to developing and planning policy implementation and leading service delivery for people with learning disabilities. Recent government policy has focused on involving service users (DH 2002, 2003, 2005, 2006b 2007a, 2007d, Mencap 2004, National Patient Safety Agency 2004). It is therefore important to evaluate research on service users' perceptions of nursing care (Aylott 2002).

## Literature search strategies

The review focused on two broad groups of studies. The first centred on the public health role of learning disability nurses and their involvement in public health policy implementation. The second looked at the experiences of people with learning disabilities in accessing public health services.

The work involved undertaking a computer database search using ERSOhost, CINAHL, Academic Search Elite, Ovid Online, IBSS, Index to Theses, PsycARTICLES, ScienceDirect, RCN Online Journals Database, ZETOC Search, Google Scholar and

Copernic Plus. Search words were placed into two categories. One category contained the following key terms: learning disability, learning difficulty, mental retardation, intellectual disability. These were combined with words or phrases pertinent to the review: learning disability nurse, community learning disability nurse, role, public health, health promotion, public health policy, health care, views, perceptions.

Studies were excluded if they were published before January 1980, not in English, government documents or covered 'non-health' roles of nurses.

The search produced 75 relevant articles, which can be broken in four distinct groups:

- Studies that addressed a public health role of the learning disability nurse.
- Research that sought the perceptions and experiences of people with learning disabilities regarding access to public health/health care.
- Investigations that explored the implementation of health policy for people with learning disabilities.
- Articles that addressed the methodological challenges of carrying out perception and experience studies involving people with learning disabilities.

The literature was then read, summarised and themes identified.

#### Public health role

Bollard (2002) used case studies to provide a model of health promotion for people with learning disabilities. Marshall *et al* (2003) evaluated the impact of learning disability nurse-led health screening clinics and health promotion classes. Barr *et al* (1998) reported on a longitudinal health screening project led by learning disability nurses. The other five papers (Bollard 1997, Stewart and Todd 2001, Boarder 2002, Mobbs *et al* 2002, Hames and Carlson 2006) focused on questions concerning the awareness of other health professionals in primary care about the general contribution of the learning disability nurses.

Jukes (1994) traced the origins of learning disability nurses' involvement in public health to the 1960s. In the 1980s several attempts were made to identify and clarify the contribution of community learning disability nurses (Elliot-Cannon 1981, Royal College of Nursing 1985). The Griffiths (1988) report and the NHS and Community Care Act (1990) emphasised the 'health' contribution of

learning disability nursing. More recently, the DH has emphasised the public health role of learning disability nurses in England (DH 2001, DH 2007c).

There is, however, a lack of clarity on how this role is to be carried out in practice. This is because learning disability nurses find themselves treading a fine line between health and social care services. Consequently, defining a public health role for learning disability nurses has been difficult (Mobbs *et al* 2002). It is no surprise that the role has evolved differently across England (Mobbs *et al* 2002), or that primary care and social care providers have conflicting views on nurses' public health role (McGarry and Arthur 2001). There is little research into learning disability nurses' practice and their contribution to public health services for people with learning disabilities (Boarder 2002). Recent research has concentrated on nurses' broader professional role (Mansell and Harris 1998, Alaszewski 2001, Mobbs *et al* 2002, Llewellyn and Northway 2007).

Qualitative methodologies were predominant in the research papers under review. These included a case study approach (Bollard 2002), questionnaires (Bollard 1997, Barr *et al* 1998, Mobbs *et al* 2002, Marshall *et al* 2003, Hames and Carlson 2006), a project report (Barr *et al* 1998) and semi-structured interviews (Stewart and Todd 2001, Boarder 2002). An outline of data analysis approaches was given in four studies under review. There was a content analysis (Boarder 2002), a descriptive analysis (Hames and Carlson 2006), and statistical analyses (Bollard 1997, Mobbs *et al* 2002). In all of the articles, except Bollard (1997), the authors do not pay much attention to the need for justifying their choice of research methods. Analysis and evaluation of this will be addressed in the section on methodologies.

Despite the methodological limitations highlighted here, important themes pertinent to the public health role of learning disability nurses emerge. The articles demonstrate high levels of health need among people with learning disabilities and the importance of action to improve access to public health services. Some of the emerging themes include the complexity and increasingly specialised role of the learning disability nurse (Mobbs *et al* 2002), the learning disability nurse's contribution to public health through health facilitation, health promotion and health education (Barr *et al* 1998, Bollard 2002, Marshall *et al* 2003), and the positive regard for learning disability nurses by other primary care professionals (Stewart and Todd 2001).

However, some of the emerging themes raise significant questions, which need further research. The lack of in-depth research studies that evaluate and validate the public health role of learning

*Learning disability nurses find themselves treading a fine line between health and social care services*



disability nurses has not been addressed. Of even greater concern, perhaps, is the lack of public health role clarity among learning disability nurses themselves, other public health professionals and primary care organisations generally (Stewart and Todd 2001, Boarder 2002, Mobbs *et al* 2002, Hames and Carlson 2006). Studies have shown that a lack of role clarity impedes the implementation of health policy (Ross 2001, Fyson 2002). Taylor (1996) pointed out that lack of role clarity and confused and ambiguous expectations among healthcare professionals result in reduced quality of care. Clarity of role expectations is beneficial because it improves communication, flexibility and responsiveness at every level of policy implementation (Taylor 1996).

### Health experiences

There is a growing amount of research literature on the involvement of people with learning disabilities in research (Townson *et al* 2004, Walmsley 2004). However, there appear to be few studies that have examined the experiences of people with learning disabilities in accessing health care. Cameron and Murphy (2002) point out that a recent focus has been on how to involve people with communication difficulties meaningfully in research. This will be addressed in more detail in the section on methodologies.

Of the four studies under review in this section, the study by Martin *et al* (1997) was the most in-depth. It sought to identify the expectations and experiences of people with learning disabilities and their carers about the health care they were receiving. The paper by Manthorpe *et al* (2003) reported on the views of people with learning disabilities and their carers on the changing roles and pre-registration education of learning disability nurses. The study by Young and Chesson (2006) investigated methods enabling people with learning disabilities and severe mental illness to comment on their health care. Chou *et al* (2008) examined whether women with a learning disability in an institution in Taiwan could comment on their experience of menstruation.

Martin *et al* (1997) used multiple methods to collect data. The other studies used focus groups (Manthorpe *et al* 2003), semi-structured interviews (Chou *et al* 2008) and structured interviews (Young and Chesson 2006). Only two studies explained how data were analysed: Manthorpe *et al* (2003) used thematic analysis and Chou *et al* (2008) used comparative analysis. Only Manthorpe *et al* (2003) highlighted the advantages and limitations of their methodologies.

Informants have been used in research into the experiences of people with cognitive disabilities (McLoughlin *et al* 1996, Gilbert 2004). Manthorpe *et al* (2003) and Martin *et al* (1997) used carers as informants in their triangulated studies. Data from service users and carers were collected and analysed separately. Chou *et al* (2008) used in-depth interview questions answered by participants 'with assistance' from carers. There may be significant methodological questions about the outcomes of this research, given that there is evidence to suggest that people with learning disabilities can easily be influenced by others when responding to questions (Fraser and Fraser 2001).

A number of themes emerge. First, people with learning disabilities can be aware of their health needs. Second, people with learning disabilities can comment on their experience of health and health care. Third, people with learning disabilities can express their views on the contribution professionals make to their health care. Townsley (1995) noted that people with learning disabilities are increasingly being involved in evaluating services. *Valuing People* (DH 2001) saw a significant contribution from people with learning disabilities. Walmsley (2004) suggested that obtaining the views of service users is now a 'moral' requirement. However, what is missing from the studies under review here are narratives from people with learning disabilities about the learning disability nurse's contribution to their experience of accessing public health services.

How people perceive their experience of healthcare activity is likely to affect their future engagement with that activity (Zastowny *et al* 1995). It is therefore important to investigate how that experience is affected by learning disability nurses' involvement.

### Health policy implementation

McDonnell *et al* (2006) pointed out that UK health policy is usually implemented or changed without evaluation. In addition, evaluation of health policy implementation has been neglected (Hill 2003, O'Toole 2004), leading to difficulties in determining whether such policy has been effective. Greenhalgh *et al* (2004) identified the need for action, as articulated by opinion leaders in health care.

The only research study under review is that by Fyson (2002). This research investigated why health and social care policies for people with learning disabilities are difficult to implement and why there is such a disparity between policy and practice. The extensive study involved semi-structured interviews with staff at all levels in learning disability services. Of interest among the findings is the variation

across geographical regions in the interpretation of national policy frameworks.

Northway *et al* (2007) pointed out that translating policy frameworks into operational policies is complex. In addition, policy effectiveness is dependent on implementation (Barrett 2004) and the staff involved (Lipsky 1993, Northway *et al* 2007). Policy effectiveness is likely to affect service user experience. Therefore, research on how policy is implemented and its impact on service users is of importance and significance (Fyson 2002).

### Research methodologies

Lack of justification for choice of methodologies is evident in most of the articles in this review.

This is surprising given that interpretive research methodologies have long been criticised for a

lack of rigour (Stringer 2007). The value and status placed on outcomes of research is largely dependent on the quality and rigour of methods used (Mays and Pope 2000).

There is increasing involvement of people with learning disabilities in service evaluation (Lowe 1992) and in research (Gates and Waight 2007) through focus groups. Focus groups are widely used in health research (Oliva *et al* 1999) and increasingly in qualitative research involving people with learning disabilities (McCallion and McCarron 2004, Gates and Waight 2007). McCallion and McCarron (2004) noted that focus groups are one of the most inclusive and relevant research approaches in learning disabilities. Another noted advantage of focus groups is their value in addressing complex issues (Basch 1987).

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However, inclusive research for people with learning disabilities using focus groups has significant challenges and criticisms (Owen 2001, Brown 2007, Gates and Waight 2007). Straw and Smith (1995) observed that focus groups with vulnerable people can easily become therapy sessions. Carey (1995) and Morgan (1988) pointed out that there are concerns regarding data analysis using this methodology.

Case studies (Fraser and Fraser 2001, Gates and Waight 2007) were used to evaluate focus groups in research involving people with learning disabilities. Boland *et al* (2008) emphasised the need for triangulation when using focus groups. All the studies acknowledged the challenges researchers face when using focus groups with people with learning disabilities, and Fraser and Fraser (2001) and Gates and Waight (2007) offer advice on how

these challenges can be addressed in practice. What is missing from the three studies is an evaluation of how data are processed and analysed. However, it is clear that focus groups involving people with learning disabilities are useful in exploratory, evaluative and longitudinal health research. Internal and external validity of data can be enhanced by triangulation to confirm conclusions.

## Conclusion

This literature review has demonstrated a need to evaluate nurses' contribution to public health policy implementation. There is also a need to evaluate and validate the experiences of people with learning disabilities' in accessing public health; the review has highlighted a dearth of research evidence in this area (Langan *et al* 1994, Lennox *et al* 2000).

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# The role of job descriptions in learning disability nursing practice

Kay Mafuba explains why clarity and accuracy of job specifications are crucial to healthcare professionals, particularly at times of change in the NHS

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## Abstract

Community learning disability nurses need clear specification of the expectations and boundaries of their roles, particularly when they work with public health responsibilities in professional and geographical isolation. Current NHS reorganisation makes clear and detailed job descriptions indispensable to prevent role conflict in the work environment, and to ensure proper delivery of public health services to people with learning disabilities. This article explores the importance of job descriptions and job specifications in community learning disability nursing. It presents a definition of a job description, explores work in the literature on the purpose of job descriptions and discusses the effect of job descriptions on public health role enactment by community learning disability nurses.

## Keywords

Community nursing, job description, public health role

IF LEARNING disability nurses are to fulfill their roles effectively, their organisations must ensure that their job descriptions are clear and accurate. Equally, nurses' understanding of what is expected of them depends on how they perceive their jobs (Saha 2008).

A job description is a form of contract between an organisation and its employees. It should highlight employers' expectations and priorities, and the professional values expected of employees (Sidani and Irvine 1999, Stenmark 2000, Ducey 2002, Levin and Weiss-Gal 2009). It should also clarify the boundaries and content of jobs (Torrington *et al* 2002).

This does not mean that job descriptions for community learning disability nurses represent all

that is expected of them in fulfilling their public health roles, but such descriptions should make clear what employers can expect from their employees (Levin and Weiss-Gal 2009) and demonstrate organisations' commitment to policies.

Forchuk *et al* (2002) call the job description a 'cornerstone for the employer and the employee in understanding job function, responsibilities, accountability and authority in the workplace'. They add that job descriptions are often reflections of the organisation's philosophies and values.

Clear, written job descriptions articulate the skill sets needed in specific roles, communicate employers' role expectations, and express formal instructions for responsibilities (Wick 2007). They are crucial, therefore, in work environments where roles and responsibilities overlap, or where there is significant distance between roles and responsibilities (Torrington *et al* 2002). Clear job descriptions are particularly valuable to community learning disability nurses, who often work in professional or geographical isolation.

According to Greshing-Pophal (2000), there is a widespread view that job descriptions serve a critical purpose in ensuring that job holders have consistent expectations about the requirements of their positions. Thus, when roles are clearly defined, and are mutually understood and accepted, there is less ambiguity about performance of duties (Marino 2005). This means that, if community learning disability nurses have clear job descriptions, they can better understand the public health roles they are expected to play and policies they are expected to implement for service users. Moreover, when employees are clear about their responsibilities, they are more likely to be effective and efficient in discharging their duties (Wick 2007).

**Table 1** Extracts from national profiles and knowledge and skills framework details for community learning disability nurses

Band	Patient care role	Policy role	Knowledge and skills framework role
5	<ul style="list-style-type: none"> <li>■ Develop healthcare programmes.</li> <li>■ Provide specialist advice.</li> <li>■ Assess healthcare needs.</li> </ul>	<ul style="list-style-type: none"> <li>■ Follow policies that are relevant to their roles.</li> <li>■ Contribute to policy development.</li> </ul>	To contribute to the promotion of, and prevention of, adverse effects on, clients' health and wellbeing.
6	<ul style="list-style-type: none"> <li>■ Develop and implement specialised care programmes.</li> <li>■ Provide specialist advice.</li> <li>■ Assess healthcare needs.</li> </ul>	<ul style="list-style-type: none"> <li>■ Implement policies.</li> <li>■ Propose changes to practices or policies in their own areas.</li> </ul>	To plan, develop and implement approaches to promote, and prevent adverse effects on, clients' health and wellbeing.
7	<ul style="list-style-type: none"> <li>■ Develop and implement specialised healthcare programmes.</li> <li>■ Provide specialist advice.</li> </ul>	<ul style="list-style-type: none"> <li>■ Propose changes to practices or policies that effect services beyond their own areas.</li> <li>■ Participate in working groups to develop learning disability policies that effect services beyond their own areas.</li> </ul>	To plan, develop, implement and evaluate programmes to promote, and prevent adverse effects on, clients' health and wellbeing.
8	<ul style="list-style-type: none"> <li>■ Deliver specialist care to multidisciplinary teams across all healthcare sectors.</li> <li>■ Are accountable for service delivery.</li> </ul>	<ul style="list-style-type: none"> <li>■ Take responsibility for policy interventions.</li> <li>■ Take responsibility for service development.</li> <li>■ Develop and implement integrated care policies.</li> </ul>	To promote, and prevent adverse effects on, clients' health and wellbeing by contributing to the development, implementation and evaluation of related policies.

Werther and Davis (1993) found that job evaluations are useful in assessing the relative importance of jobs, while Welbourne and Trevor (2000) state that job evaluations are necessary if the contribution of each job to each organisation is to be assessed.

### Self-directed work

Despite these findings there is an argument that job descriptions inhibit staff's ability to be innovative (Torrington *et al* 2002), while Wick (2007) suggests that job descriptions may be becoming obsolete in community learning disability practice, where self-directed, lone working is common. Wick (2007) adds, however, that they remain indispensable in NHS organisations if role conflict and chaos in the work environment are to be avoided, particularly at times of NHS reorganisation.

There are several studies of the job descriptions of nurses in the literature, but none specifically about the job descriptions of community learning disability nurses could be found.

Research involving nurses in Taiwan was undertaken by Wei *et al* (2011), who conclude that nurses who received explicit job descriptions had positive perceptions of their roles. In the United States, Grant (1997) undertook a study involving staff from 60 different organisations. Of those

who participated in the study, 85 per cent said that their job descriptions did not define their employers' expectations. The managers' failure to be clear about their expectations was based on an assumption that staff knew what these roles and responsibilities were.

In an investigation of nurse consultant roles in Australia and England, Endacott and Chaboyer (2006) found that, in both countries, it is stated in nurse consultants' job descriptions that they are expected to influence hospital policy (Endacott and Chaboyer 2006).

Kudless and White (2007) examined mental health nursing roles. They found that, at times of change to policies and clinical environments, job descriptions, including those of community learning disability nurses, should be clear.

In the UK, the introduction of Agenda for Change (Department of Health (DH) 1999) has involved a re-evaluation of the jobs and job descriptions of all staff who work in the NHS. Since then, there have been numerous studies of its effect on nursing (Jay and Tanner 2004, Watts and Green 2004, Bridges *et al* 2007, Jenkins 2007, Kahya and Oral 2007, Buchan and Ball 2010, McClimens *et al* 2010).

One of the key purposes of Agenda for Change is to ensure consistency of job specifications across the NHS. According to its job classification for



nursing, there are six groups of roles, of which one is community nursing (Kahya and Oral 2007). Jobs are evaluated and roles are defined according to 16 'factors'.

These factors encompass knowledge, experience, skills, responsibilities, role effort, degree of freedom to act and conditions under which roles are enacted. Each factor has clear requirements for the respective nursing bands as in the examples in Table 1.

Agenda for Change also involved the development of the NHS knowledge and skills framework (KSF) (DH 2004), which outlines the responsibilities of nurses on each band and groups these into 'dimensions'. One dimension, called HWB1, for community learning disability nurses,

for example, outlines their roles in the promotion of health and wellbeing and prevention of adverse effects on health and wellbeing. Evaluating the accuracy of these dimensions is an important area for future research.

Table 1 presents an outline of the community learning disability nurse role as it relates to patient care and to policy, and details of the relevant KSF dimension. A similar job description for community learning disability nurses can be found in the three domains and nine key areas of public health practice published by the Faculty of Public Health (2012), which is the standard-setting body for public health professionals and specialists in the UK.

### Online archive

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Conflict of interest  
None declared

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Feature

# Going public: how government policy affects service provision

Kay Mafuba outlines the relationship over recent years between national policies and the care of people with learning disabilities

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## Abstract

This article discusses the complexity of UK public health policy, and how it affects learning disability nurses and service users, especially in light of the recent shift in emphasis from the provision of treatments to the introduction of preventive interventions. Learning disability nurses must update their knowledge of public health policy to be able to carry out these interventions effectively.

## Keywords

Learning disability nursing, public health policy

PEOPLE WITH learning disabilities have more healthcare needs, yet have poorer access to health care, and are more likely to be given inadequate diagnoses and to die from preventable illnesses, than the average for the general population (Kerr 2004, Mencap 2004, National Patient Safety Agency 2004, Department of Health (DH) 2006a, 2007, Disability Rights Commission (DRC) 2006, Mencap 2007). In addition, uptake of public health initiatives by service users is poor (DH 2008a).

To ensure such initiatives improve healthcare outcomes, nurses need to understand what constitutes public health. This is a contentious subject (Dawson and Verweij 2007, Kaiser and Mackenbach 2008, Baggott 2011), in part because the meaning of 'health' itself is subject to debate (Blaxter 2004). Nevertheless, the DH has adopted Acheson's (1998) definition of public health as: 'The science and art of preventing disease, prolonging life and promoting health.'

Meanwhile, the Faculty of Public Health has identified nine areas of public health practice:

- Strategic leadership and collaboration for health.

- Surveillance and assessment of the population's health and wellbeing.
- Assessment of evidence of effectiveness of healthcare interventions, programmes and services.
- Policy and strategy development and implementation.
- Health improvement.
- Health protection.
- Health and social service quality.
- Public health intelligence.
- Academic public health.

Public health policies differ across the four countries of the UK, and this divergence has become more pronounced since devolution (Greer 2009).

In England, the DH (2004a) has identified six priorities for public health:

- Reducing the number of people who smoke.
- Reducing the number of people who are obese, and improving diet and nutrition.
- Encouraging people to exercise.
- Encouraging people to drink alcohol sensibly.
- Improving people's sexual health.
- Improving people's mental health.

## Policy initiatives

Over the past few years, the DH has adopted a series of other public health policy initiatives to improve specific areas of health and wellbeing, and reducing health inequalities (DH 2006a, 2006b, 2007, 2010).

In Scotland, before devolution, targets had been set to reduce incidence of coronary heart disease and cancer among the population (Scottish Office 1992). Since devolution, however, other policies intended to improve health and reduce health inequalities (Scottish Executive 2003, Scottish Government 2007).

In recent years, public health policy in Northern Ireland (NI) has tended to focus on enhancing life

expectancy, as well as on reducing health inequalities and the future of public health in NI (Department for Health and Social Services 2002, 2004, NI Executive 2008). Meanwhile, the Public Health Agency (2011) has led studies of the health needs of people with mental health problems or learning disabilities in NI.

Wales was the first UK country to develop a comprehensive public health strategy (Welsh Office NHS Directorate 1992). Its priorities were:

- Reducing incidence of cancer.
- Improving maternal and child health.
- Improving emotional health.
- Reducing respiratory illness.
- Reducing incidence of cardiovascular disease.
- Improving care for people with learning disabilities.
- Reducing the incidence of mental distress and mental illness.
- Making the environment healthier.

Since then, a series of further public health policy initiatives emphasising the need to address health inequalities have been issued (National Assembly for Wales 2001, Welsh Assembly Government 2002, 2005b).

### Contract

The DH (2004b) GP contract identifies three distinct groups of services:

- Essential services, such as consultations.
- Additional services, such as immunisation and screening.
- Enhanced services, such as annual health checks for people with learning disabilities.

Additional and enhanced services are not regarded as compulsory parts of the contract, which means that important aspects of public health policy delivery are optional at the primary care level.

In 2008, additional payment for the provision of clinical directed enhanced services was added to the contract (NHS Employers and British Medical Association 2009). This addition was intended to improve access to public health services.

Public health policy in the UK can best be described as uncoordinated. The first learning disability-specific public health-focused policy, *The Health of the Nation* (DH 1995) promoted a healthy lifestyle, mainly through diet, exercise and sexual health education.

Four years later, the NHS Executive (1999) acknowledged that service users were experiencing poor access to services in the NHS and published examples of care pathways in mainstream services. The executive highlighted the challenges people with learning disabilities must overcome when accessing services.

In *Valuing People: A New Strategy for Learning Disability for the 21st Century* (DH 2001), the DH emphasised the need to improve the health of clients in England and Wales. The Scottish Executive (2000) adopted a similar approach. Thus the complexity of the healthcare needs of people with learning disabilities, and the inadequacies of existing models of healthcare provision, were acknowledged.

Subsequently, Mencap (2004) has suggested how clients' access to health care could be improved, while the Disability Rights Commission (2006) has discussed what it claims is an inadequate response from the NHS, and the English and Welsh governments, to the physical health inequalities experienced by service users.

In Scotland, NHS Health Scotland (2004) discerned the health needs of such people and provided guidance for healthcare professionals on how these could be met.

In *Death by Indifference*, Mencap (2007) alleged there is institutional discrimination in the NHS, that results in people with learning disabilities receiving ineffective health care. The report presents the stories of six individuals who had died, according to the authors, because the healthcare professionals caring for them did not understand their healthcare needs. The government's response to the deaths was published by the Parliamentary and Health Service Ombudsman (2009). Meanwhile, the DH (2008b) described how such people struggle to access health care and can receive ineffective treatment.

Although these policies and reports identify relevant public health issues, few of them discuss the public health needs of clients. The objectives of some of the authors are ambitious but implementation of their ideas has been left to local organisations and so has tended to be disorganised (Mansell 2008).

Many recent reports have shown how poor implementation of policies affects care delivery (DRC 2006, Mencap 2007, DH 2008b, Parliamentary and Health Service Ombudsman 2009).

Because there is no agreed national framework on how to implement public health policies and initiatives for people with learning disabilities, service providers take an ad hoc approach to health-policy implementation (Mansell 2008).

As the shift towards a preventive health approach gathers pace, learning disability nurses must focus on health promotion. This will require them to ally themselves with other professionals, service users and other stakeholders to find ways to reduce health inequalities and improve health outcomes (Kerr 2004, Melville *et al* 2006, DH 2007).



It is unlikely that any single public health model can meet the needs of all people with learning disabilities, but there are two such models, devised by Tannahill (2009) and Beattie (1991), that nurses should assess.

The Tannahill (2009) model emphasises the overlapping nature of three aspects of public health: education, prevention and protection. Nurses who adopt the model can engage in health-education programmes to raise awareness of health issues and encourage behavioural change.

Meanwhile, by helping clients adopt health-prevention measures and participate in health screening, nurses can reduce the incidence of disease. They can contribute to health protection

by developing preventive policies and practices appropriate to their roles.

In advocating health persuasion, personal counselling, legislative action and community development, the Beattie (1991) model is authoritarian but also empowering. The drawback in this model is that its effectiveness depends on the competency in making choices of individual clients.

As this article shows, the current evidence base on the effectiveness of existing public health policies is limited. Nevertheless, learning disability nurses can make a significant contribution to this evidence base by researching the implementation of public health policies that affect people with learning disabilities.

### Online archive

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Conflict of interest  
None declared

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Article



# Sequential multiple methods as a contemporary method in learning disability nursing practice research

Journal of Intellectual Disabilities  
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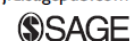
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## Abstract

This paper explores and advocates the use of sequential multiple methods as a contemporary strategy for undertaking research. Sequential multiple methods involve the use of results obtained through one data collection method to determine the direction and implementation of subsequent stages of a research project (Morse, 1991; Morgan, 1998). This paper will also explore the significance of how triangulating research at the epistemological, theoretical and methodological levels could enhance research. Finally the paper evaluates the significance of sequential multiple method in learning disability nursing research practice.

## Keywords

research methods, sequential multiple method, learning disability nursing research

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## Introduction

This paper will explore the use of sequential multiple method. This was originally used within a UK wide research project investigating how community learning disability nurses perceived and

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enacted their public health roles (Mafuba, 2012) and is used within this paper to contextualise the use of the sequential method. This study adopted 3-stages; the first was the exploratory stage, which involved examining job descriptions; documentary analysis. In the second stage UK learning disability nurse consultants were interviewed and transcripts were carefully analyzed using grounded theory. The third stage; the explanatory stage, involved a UK survey of community learning disability nurses. The use of multiple methods in a single study has existed for some time in social research (Campbell and Fiske, 1959; Erzberger and Prein, 1997); and recently there has been growth in multiple-method research studies (Green et al., 2001) including nursing. The extent and value of multiple methods in nursing research have been highlighted (Halcomb and Andrew, 2005). However, very little attention has been paid to highlight the potential of sequential multiple methods in nursing research. This paper seeks to make a contribution to the research literature to address this absence of methodological and theoretical interest particularly in learning disability nursing research.

### **Definitional issues**

Multi-method, mixed methods, multiple methods and triangulation refer to the concurrent or sequential use of more than one approach in a study at the methodological level (Barbour, 1998; Byrne and Humble, 2006; Creswell, 2009; Denzin, 1962; Morse, 2003; Treddlie and Tashakkori, 2003). However, to fully benefit from the potential of multiple-method designs, integration needs to be at the epistemological, theoretical and methodological levels. In this article, the term *multiple methods* is used in a context of the study design (Shih, 1998), and triangulation is used in the context of the process of implementing a multiple-method design research study (Thurmond, 2001).

### **Cosmology, ontology and epistemology**

To fully realise the potential of sequential multiple-method study designs, the connectedness of and interaction between cosmology, ontology, epistemology and methodology in the generation of new knowledge (Crotty, 1998) need to be understood. Cosmology refers to one's worldview and in essence this influences how a researcher approaches a study design. Cosmology directly influences one's ontology, or the claims, and assumptions the researcher makes regarding the nature of social realities, assumptions about what exists, and what that existence looks like, and how what exists interacts with each other (Blaikie, 2000). It is important that every researcher clarifies and is conscious of his or her underlying philosophical position in order to fully appreciate the potential of sequential multiple-method research designs. In designing a sequential multiple-method study, understanding the epistemology is crucial in ensuring that the rules of correct knowledge creation and belief formation are explicit (Breachin and Sidell, 2000) in the phenomenon under investigation. Potential users of sequential multiple-method study designs will find the works of Guba and Lincoln (2005), Geertz (1988) and Eisner (1999) useful in locating their epistemological positions within the current contradictions in order to design sequential multi-epistemological studies.

Sequential Multiple Methods QUAL → quan Notation (Morse 2003)				
Epistemological Continuum				
		Stage 1 (Exploratory phase)	Stage 2 (Descriptive phase)	Stage 3 (Explanatory phase)
Theoretical Perspective		Interpretivist	Interpretivist	Positivist
Methodology		Documentary	Grounded Theory	Survey
Methods	Method	Documentary analysis	Semi-structured interview	Online survey questionnaire
	Participants	Job descriptions Person specifications	Learning Disability Nurse Consultants Other Senior NHS Nurses in LD Practice	Community Learning Disability Nurses
	Sampling	Purposive (Glasser & Strauss)	Purposive + Theoretical	Non-proportional quota
	Data Analysis	Content / Thematic Nvivo 8	Constant Comparative / Thematic Nvivo 9	Descriptive / Inferential Statistics SPSS19

**Figure 1.** Example of a three-stage sequential multiple method research study design (based on Crotty, 1998 and Morse, 2003).

## Types of triangulation

There are six types of triangulation that could be used in sequential multiple-method study designs (theoretical, methodological, data source, multiple, investigator, and analysis). Theoretical, methodological and data source triangulation appear to be the most commonly used in nursing studies, and these are considered here (Begley, 1996; Foss and Effelsen, 2002; Thurmond, 2001). One reason for the lack of literature on the interaction between cosmology, ontology and epistemology, and how these positions could be reconciled in study designs could be that researchers thus far may consider it more important to maintain their positions at these theoretical levels.

*Theoretical triangulation.* It is the use of multiple theories or hypotheses to investigate a phenomenon (Corner, 1991; Cowman, 1993; Denzin, 1970; Kimchi et al., 1991; Nolan and Behi, 1995; Shih, 1998). Denzin (1970) and Banik (1993) further explained that theoretical triangulation looks at testing opposite theories. The process of theoretical triangulation could involve the same data set or different data sets (Boyd 2000). In the example given here, different data sets were triangulated. In this approach, the researcher needs to pre-empt and address the possibility of non-convergence of data.

According to Burns and Grove (1993), theoretical triangulation could result in poor studies if the rationale for using it is not clearly defined at the beginning of the project. It is therefore



important to conceptualise from the diagram how the overall design fits together and at different levels (see Figure 1). Furthermore, researchers need to be cognizant that analysing data and interpreting results from data collected using quantitative and qualitative methods in a study could be difficult (Banik 1993). It is therefore important that adequate controls are put in place. Sequential multiple methods could provide effective controls in that each stage of the study is treated as an independent study in its own right. This makes it possible for the theoretical drive of each stage to be clarified without ambiguity. This is important because it makes it easier to clarify a study's epistemological position. This is also important as Lincoln and Guba (1985) have further pointed out that triangulation could be epistemologically faulty if this is not clarified at the beginning of a study. It is therefore important that research undertaken using multiple methods is clearly located on the epistemological continuum. They also noted that findings could be difficult to interpret if the underlying constructs and concepts are the same or overlap (Lincoln and Guba, 1985).

*Methodological triangulation.* It is more complex and confusing (Goodwin and Goodwin, 1984). The main confusion seems to arise when it is used to describe triangulation at either the design or data collection levels (Cowman, 1993; Goodwin and Goodwin, 1984; Kimchi et al., 1991; Lincoln and Guba, 1985; Morse, 1991; Shih, 1998). In addition to discussing methodological triangulation from study design and data collection perspectives, it is also further divided into within-method triangulation and between- or across-method triangulation. In the within-method approach, at least two data collection strategies (both qualitative or both quantitative) from the same paradigm are used in studying the same phenomenon (Begley, 1996; Kimchi et al., 1991; Nolan and Behi, 1995; Thurmond, 2001). On the other hand the across-method approach uses a mixture of qualitative and quantitative strategies to measure the same variable (Denzin, 1970; Kimchi et al., 1991; Mitchell, 1986; Nolan and Behi, 1995; Thurmond, 2001).

The purpose of qualitative and quantitative studies is basically similar in that all research intent to gather evidence or generate new knowledge. The existing debate is how evidence of a particular phenomenon is gathered or how knowledge is created. It could therefore be argued that combining methods within the same paradigm is possible and sensible in order to have a clearer picture of a phenomenon from qualitative and quantitative data (Dzurec and Abraham, 1993; Lincoln and Guba 2000). It could be argued that research that reconciles interpretative and positivist worldviews is useful in presenting a more holistic view of a phenomenon. Another attraction of methodological triangulation is that it has the potential to compensate for the weaknesses of one method with the strengths of the other (Corner, 1991; Morgan, 1998; Morse, 1991; Thurmond, 2001). According to Morse (1991), this is particularly useful when combining interviews or focus group data with survey data.

Methodological triangulation is not without its limitations, and it is important for researchers to be aware of these criticisms throughout the research process. Some critics have argued that qualitative and quantitative approaches differ fundamentally at the ontological and epistemological levels and because of this it is impossible to combine the two in one study at the methodological level (Dzurec and Abraham, 1993). However, this could be addressed by ensuring that each method is rigorous and robust enough to be sustainable on its own (Morse, 1991). It is also important that researchers be aware of the warning made by Fielding and Fielding (1986) that data error from one approach could not be compensated by accuracies in another approach.



*Data source triangulation.* This refers to the use of multiple sources of data to explore the same phenomena (Begley, 1996; Cowman, 1993; Kimchi et al., 1991; Nolan and Behi, 1995; Shih, 1998). In addition, the triangulation of data can be in the context of time (Denzin, 1970; Kimchi et al., 1991), place (Kimchi et al., 1991; Mitchell, 1986) and person/participant (Denzin, 1970; Kimchi et al., 1991). In the context of the research given in the article, time and place were not of interest, and therefore these are not explored any further here. In data source triangulation in the context of participants, data are collected from more than one level of people involved in the phenomenon under consideration (Denzin, 1970; Kimchi et al., 1991). Triangulating data at the participant level present a number of benefits in sequential multiple-method study designs. Banik (1993) highlighted the significance of increasing the volume of data, which is enabled by the process of triangulation. In addition, according to Fielding and Fielding (1986), triangulating the source of data in the context of the participants has the potential to enhance the confidence levels in the data. Improving the confidence levels is important in any study, whether it is qualitative or quantitative. In the example given here, job descriptions and person specifications were used to explore how public health policy was interpreted and translated into job roles by employers. This was not only useful in the exploration of the phenomenon under consideration but was also useful in the theoretical sensitisation of the researcher. In the descriptive phase of the study learning disability nurse consultants and others were interviewed to explore further the findings from the exploratory phase of the study. In this stage, a mid-range hypothesis was generated. In the explanatory phase of the study, a wider and larger group of community learning disability nurses was surveyed using an online questionnaire in order to explain the correlations in the hypothesis generated in stage 2 of the study. The large volume of data collected was useful in enhancing the confidence in the data and therefore the findings.

Data triangulation is not without challenges. It is very likely that a large amount of data would be generated, which would be essential in enhancing the confidence levels, handling, analysing and interpreting large amounts of data have the potential for errors, resulting in wrong interpretation of the findings (Porter, 1989; Thurmond, 2001).

## **Sequential multiple methods**

This approach is invaluable in that it allows the researcher to make adjustments and refine each subsequent stage following the findings from the preceding stage.

A clearer understanding of the value of sequential multiple methods in learning disability nursing practice can be further aided by the work of Breechin and Sidell (2000). They created a three-lens framework of 'knowing', which could be useful in articulating and operationalising this complex but very valuable approach to research. The three lenses overlap, overarch and represent different windows through which the world could be viewed (Breechin and Sidell, 2000). The authors have argued that how researchers choose a lens or multiple lenses in looking at a phenomenon is dependent on the motivation for seeking evidence or knowledge. The fact that these lenses could be used sequentially fits very well with sequential multiple-method study design. Applying the first lens to a multiple-method design such as in the example here is useful in looking at the importance of how capacity for prediction and control (positivist) could be improved. This approach is important in building capacity in the exploratory phase, which would improve the generalisability of the findings in the explanatory phase of a study and the knowledge that emerges. In the example under consideration here, stage 3 employed the use of a survey questionnaire to verify the themes that emerged from

stages 1 and 2. It was therefore necessary that in stage 3 of this study that it had to be located within a deductive positivist approach to test the theories that emerged in stages 1 and 2.

The second lenses enable the researcher to focus on developing an understanding and exploration of meanings (Breachin and Sidell, 2000). In brief, stages 1 and 2 were devoted to theoretical sensitisation and theory generation (Glaser and Strauss, 1967; Layder, 1993). This is important since Parahoo (2006) has noted that most theories emerge from what is already known. According to Glaser and Strauss (1967), theory generation is crucial in creating new knowledge. They argued for the need for inductive research to be seen as a preliminary stage in a project, and they saw this process as more capable of producing relevant propositions. They further argued that the findings obtained through the inductive process need to be tested quantitatively later. What is perhaps even more important for researchers learning disability nursing practice is their positivist stance that prediction and control are important in explaining observed behaviour (Glaser and Strauss, 1967). Simply, this explains a view that a sequential multiple-method approach to nursing research is useful and important in generating new and relevant knowledge.

The third lens suggests that research could be viewed as a method of promoting social values (Breachin and Sidell, 2000). Lairumbi et al. (2008) have argued that research needs to make contributions to the values of the society in which it is undertaken. This is important for researchers to understand because translating research into policy and practice is difficult and complex (Lavis, 2006). The implication of this being that research that is undertaken ethically, and which promotes society's social values is more likely to inform, and influence policy, and practice. In the example given here, the research undertaken here involved how community learning disability nurses enacted their public health roles in implementing public health policy for people with learning disabilities. It could be argued that this research has significant social value.

As mentioned earlier, the example given here is of a 3-stage exploratory, descriptive and explanatory study. The design involved qualitative and quantitative projects, which are relatively complete in their own right. Creswell (2009) provides a very useful checklist of 12 items that could be used during the process of a multiple-method study design.

Sequential implementation can be exploratory or explanatory (Creswell, 2009). In an *explanatory sequential multiple-method research design*, quantitative data are collected and analysed before qualitative data are collected in order to contextualise the statistical data (Byrne and Humble, 2006). On the other hand, in an *exploratory sequential multiple-method research design*, qualitative data are collected in order to explore a phenomenon or phenomena, and then quantitative data are collected with the aim of explaining the relationships observed in the exploratory phase of the research (Byrne and Humble, 2006). The example given here is the latter (see Figure 1 above). This design has predominantly an inductive theoretical drive and has a QUAL → quant notation (Creswell, 2009; Morse, 2003). This means that the predominant components of the study were qualitative. It is important to point out that the notation of a sequential multiple-method study design needs to be dictated by the question under consideration.

### *Strengths of sequential multiple methods*

Sequential multiple methods need to be approached from a position that it is impossible for one research method to be able to provide a holistic view of complex phenomena (Cowman, 1993; Denzin, 1989; Sandelowski, 2000) and this is often common in learning disability nursing



research. The use of sequential multiple methods is therefore essential in order to capture the context and social complexities associated with experience and perception studies (Hammersley and Atkinson, 1995; Sayer, 1992; Shih, 1998). In addition, triangulation increases validity, strength, and interpretative potential of a research study and reduces investigator biases (Denzin, 1970). Campbell and Fiske (1959) who are credited with introducing multiple methods noted that triangulation enhanced validity through data confirmation. In addition, multiple methods are considered to be useful in shedding light on the phenomenon under investigation from different viewpoints (Coyle and Williams, 2000; Fielding and Fielding, 1986). Furthermore, the point raised by Halcomb and Andrew (2005, p.73) that triangulation at the epistemological level provides a '*completeness of understanding*' of the phenomenon and consideration is rational and reasoned. Holman (1993) also noted that qualitative and quantitative methods complement each other in health care studies. The literature cited here suggests that using sequential multiple-method approaches is more likely to generate valid and reliable knowledge than a single method approach.

### *Weaknesses of sequential multiple methods*

Perhaps the greatest potential weakness of sequential method is incompatibility of different cosmological, ontological, and epistemological positions, which researchers and consumers of research may hold. Questions and contentions over validity of multiple-method research contribute to the perceived weakness of sequential multiple-method studies. Findings from sequential multiple methods could be difficult to locate within the traditional objectivist or objectivist positions. Researchers' and consumers' worldviews are important because they influence acceptance or rejection of research findings. In addition, these incompatible worldviews make it difficult to integrate the results from a study (Onwuegbuzie and Johnson, 2006). Furthermore, the findings from sequential multiple-method study may be difficult to compare with the findings from other studies on the same phenomenon (Onwuegbuzie and Johnson, 2006).

What is also clear from current literature is the lack of a framework, and the limited amount of information regarding how sequential multiple-method studies could be implemented (Corner, 1991). Existing literature shows that in many cases triangulation is used to increase the volume of data, without consideration of how data would enhance validity, reliability, or rigour of the results (Begley, 1996; Thurmond, 2001).

Another important drawback of using sequential multiple method is the complexity and extent of the work involved at every stage. Researchers need to be aware that putting a theoretically driven sequential multiple method study design together is challenging in itself, and requires meticulous attention to detail at every stage of the research process.

Careful consideration needs to be made to ensure that a study can demonstrate integrity and coherence all the way from the epistemological drive, right down to data interpretation and writing up of research findings. A good example of what I am referring to is that the study being discussed here employed three different methodologies, and all these had to be considered in their own right resulting in the need for three separate sections on methods, and three separate sections on results during reporting.

Another important drawback of sequential multiple methods is that it is resource intensive in terms of expense, time and researcher skills (Nolan and Behi, 1995; Shih, 1998; Thurmond, 2001). Conducting face-to-face interviews could be expensive in transport and subsistence terms if participants are spread across a wide geographical area. Sequential multiple-method studies could take a long time to implement, and could become unmanageable if they are not carefully planned.

In terms of researcher skills sequential multiple methods could be quite challenging (Thurmond, 2001). In the example given, the researcher had to develop sufficient depth of knowledge of three methodologies, three methods, two sampling methods, three data analysis methods, and three different types of data analysis software. Another potential disadvantage of triangulation is that because of the extent of the work involved, there is likely to be a limit placed on the depth of error and bias checking for each of the procedures (Begley, 1996; Nolan and Behi, 1995). Another potential difficulty, which needs to be considered carefully from the beginning, is what route a researcher would have to take in the event that findings are completely divergent (Proctor, 1998). Divergent results are likely to present problems with their interpretation. This may in turn impact on the value of the contribution to evidence or knowledge by a research study. To address this problem, each of the stages could be designed as an independent study in its own right with integration occurring in the discussion section of the reporting stage. This would allow the results to be reported separately even if they fail to converge. The second contingency would involve adopting a stance to synthesise the potential sources of the lack of convergence (Chelsea, 1992).

## Conclusion

This article has explored the relevance of and highlighted how a sequential multiple-method study design could be used in learning disability nursing practice research. It is essential that more researchers adopt sequential multiple-method study designs and report on their experiences in order to build a good evidence base for such an underused but effective approach to research.

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**Appendix 3a:** Multiple methods design checklist (Creswell 2009, p.205).

	<b>Question</b>
1	Is a basic definition of mixed methods research definition provided?
2	Is a reason given for using both quantitative and qualitative approaches (or data)?
3	Does the reader have a sense for the potential use of a mixed methods design?
4	Are the criteria identified for choosing a mixed methods strategy?
5	Is the strategy identified, and are its criteria for selection given?
6	Is a visual model presented that illustrates the research strategy?
7	Is the proper notation used in presenting the visual model?
8	Are procedures of data collection and analysis mentioned as they relate to the model?
9	Are the sampling strategies for both quantitative and qualitative data collection mentioned? Do they relate to the strategy?
10	Are specific data analysis procedures indicated? Do they relate to the strategy?
11	Are the procedures for validating both the quantitative and qualitative data discussed?
12	Is the narrative structure mentioned, and does it relate to the type of mixed methods strategy being used?



**Appendix 3b:** Ethics approval letter (Stages 1 and 2)

THAMES VALLEY UNIVERSITY  
Faculty of Health and Human Sciences  
Faculty Research Ethics Committee  
Paragon House  
Boston Manor Road  
Brentford TW8 9GA  
Tel: +44 (0)20 8209 4110/4145  
email: [fhhs.ethics@tvu.ac.uk](mailto:fhhs.ethics@tvu.ac.uk)  
[www.richardwellsresearch.com](http://www.richardwellsresearch.com)

Kay Mafuba  
Faculty of Health & Human Sciences  
Thames Valley University  
Paragon House  
Brentford TW8 9GA

23 July 2009  
Dear Kay

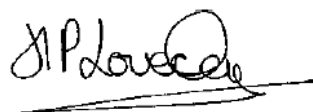
**Re: Application for Research Review Approval No. FREC43/June 09**

Thank you for your application for approval. The Committee considered your application at the meeting held on 2 July and approved phase one and two of the research. The Committee advise that you secure approval for the subsequent phases of the study as you develop the processes and methodology through the initial phases.

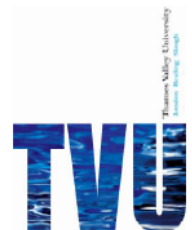
With regard to NHS REC approvals, the Committee is of the opinion that the recruitment process that you have described, which is through a professional group/ network will not require NHS REC scrutiny. However, the process for recruitment will need to be detailed and appropriate access permission provided from the networks and also MENCAP for phases two three and four.

The Committee would advise further proof reading of your supporting documentation and also that you involve service users/ carers in preparing the participant information sheets and focus group protocols for phase 4 to ensure that they are easily understandable.

Yours sincerely



Heather Loveday  
Chair, Faculty Research Ethics Committee



**Appendix 3c:** Ethics approval letter (Stage 3)



University of West London  
Faculty of Health and Human Sciences  
Faculty Research Scrutiny & Ethics  
Sub-committee  
Paragon House  
Boston Manor Road  
Brentford TW8 9GA  
Tel: +44 (0)20 8209 4110/4145  
email: fhhs.ethics@uwl.ac.uk

Kay Mafuba  
Faculty of Health & Human Sciences  
University of West London  
Paragon House  
Brentford TW8 9GA

7 April 2011

Dear Kay

**Re: Application for Ethical Approval No. FRSESC 23/April 11 – Final Stage**

Thank you for sending in the final stage of your research study, stages 1 and 2 having been approved in June 2009. The Committee has considered this and approved the research without major amendment.

If the research does not progress, or if you make any changes to your research proposal or methodology can you please inform the Committee in writing as this may entail the need for additional review. It is your responsibility, as the principal investigator, to submit a report on the progress/completion of the research twelve months from the date of this letter, or on completion of the research, whichever is the sooner. Please find attached a blank report form to be completed by April 2012.

The Committee wish you well with the research and look forward to your report.

Yours sincerely

A handwritten signature in black ink, appearing to read 'H. Loveday', with a horizontal line underneath.

Heather Loveday  
Principal Lecturer (Research)  
Chair of the Faculty Research Scrutiny & Ethics Sub-committee



**Appendix 3d:** Invitation letter and consent form (Stage 2)



Faculty of Health & Human Sciences  
School of Community Health and Social Care  
Paragon House  
Boston Manor Road  
Brentford  
Middlesex TW8 9GA

Tel: 02082094217

E-mail: [kay.mafuba@tvu.ac.uk](mailto:kay.mafuba@tvu.ac.uk)

Date: 22<sup>nd</sup> November 2010

Dear ALL

I am writing to you with regard to an impending research study being undertaken by the School of Nursing Midwifery and Healthcare at Thames Valley University.

I believe that you are the most appropriate person to approach for assistance and that you would make essential and valuable contribution to the findings of the study.

The research study will be conducted over the next 2-3 years and covers England, Wales and Scotland. It is concerned with how learning disability nurses understand their role in public health policy implementation. Current re-organisation of health and healthcare provision in the UK has highlighted the need to evaluate the contribution learning disability nurses make to healthcare provision for people with learning disabilities.

This research attempts to answer one key question and two subsidiary questions:

**Key question:**

**What is the public health role of the community learning disability nurses and how they perceive and enact their public health roles?**

***Subsidiary questions:***

- d. How is public health policy reflected in community learning disability nurses' job descriptions?
- e. What is the learning disability nurse's understanding of their public health role?

This is a 3-stage research study and involves:

1. Documentary Data / Textual Analysis of job descriptions of learning disability nurses who have roles with public health policy implementation involvement.

2. Semi-structured interviews with learning disability nurses of NHS 'Nurse Consultant' grade (equivalent) or higher who have significant involvement with public health policy implementation.
3. Postal Questionnaire survey of learning disability nurses of all NHS grades (equivalents) who are involved in public health policy implementation.

My contact with you at this point is to establish whether you would be willing to participate in the study.

You can be assured that all information collected as part of this research study will be treated in the strictest confidence. **NO PERSONAL INFORMATION** about participants and their organisations will be identified in the data collected or in any published results.

I am confident that the information in this letter is sufficient for you to make a decision to contribute to this research study. However I have enclosed a leaflet with additional information about the research study and you can contact me if you need further information.

You can confirm to give your consent and your willingness to participate by e-mailing [kay.mafuba@tvu.ac.uk](mailto:kay.mafuba@tvu.ac.uk) or telephone 02002094217 or by posting the attached return slip below.

I am looking forward to hearing from you soon.

Yours sincerely



Kay Mafuba  
Programme Leader (Learning Disabilities)

.....  
...

**Please Return To:**

K. MAFUBA  
Thames Valley University  
Faculty of Health & Human Sciences  
School of Community Health and Social Care  
Paragon House  
Boston Manor Road  
Brentford  
Middlesex TW8 9GA

I am willing to take part in the proposed study

**Yes / No**

My preferred interview method is:

**Face-to-face / Telephone**

Name:

Address:

Telephone:

E-mail:

**Appendix 3e:** Invitation letter and consent (Stage 3)



College of Nursing Midwifery and Healthcare  
Paragon House  
Boston Manor Road  
Brentford  
Middlesex TW8 9GA

Tel: 02082094217  
E-mail: [kay.mafuba@uwl.ac.uk](mailto:kay.mafuba@uwl.ac.uk)

13<sup>th</sup> July 2011

Dear ALL

I am writing to you with regard a research study being undertaken by the College of Nursing Midwifery and Healthcare at the University of West London.

I believe that you are the most appropriate person to approach for assistance and that you would make essential and valuable contribution to the findings of the study.

The research study is being conducted over 2-3 years and covers England, Wales, Scotland and Northern Ireland. It is concerned with how learning disability nurses understand and enact their role in public health policy implementation. Current re-organisation of health and healthcare provision in the UK has highlighted the need to evaluate the contribution learning disability nurses make to healthcare provision for people with learning disabilities.

This research attempts to answer one key question and two subsidiary questions:

**Key question:**

What is the public health role of the community learning disability nurse and how do they perceive and enact their public health roles?

**Subsidiary questions:**

- f. How is public health policy reflected in community learning disability nurses' job descriptions and person specifications?
- g. What is the learning disability nurse's understanding and perception of their public health role?

This is a 3-stage research study and involves:

- 4. Documentary Data / Textual Analysis of job descriptions of learning disability nurses who have roles with public health policy implementation involvement (completed).
- 5. Semi-structured interviews with learning disability nurses of NHS 'Nurse Consultant' grade or higher (equivalent) who have significant involvement with public health policy implementation (completed).

6. Survey questionnaire of learning disability nurses of all grades (equivalents) that are involved in public health policy implementation.. The research will result in a series of publications. The literature review publication, which set the rationale for this research is attached.

You can be assured that all information collected as part of this research study will be treated in the strictest confidence. **NO PERSONAL INFORMATION** about participants and their organisations will be identified in the data collected or in any published results.

I am confident that the information in this letter is sufficient for you to make a decision to contribute to this research study. However if you require further information about the research study you can conduct me using the above details.

If you are willing to participate please **CLICK** on a link that corresponds to your current grade below. **(Please NOTE THAT BY COMPLETING THE ON-LINE QUESTIONNAIRE YOU ARE GIVING YOUR CONSENT TO PARTICIPATE IN THE RESEARCH).**

[Band 5](#)

[Band 6](#)

[Band 7](#)

[Band 8+](#)

Thanks very much for agreeing to take part and supporting this very important study.

Yours sincerely

A handwritten signature in purple ink, appearing to read 'Kay Mafuba'.

Kay Mafuba  
Programme Leader (Learning Disabilities)



## **STAGE 2: SEMI-STRUCTURED INTERVIEW PROTOCOL AND QUESTIONS**

(Grounded Theory – Glaser & Strauss, 1967)

### **Study Title:**

Public Health: Learning Disability Nurse's Perception and Experience of their Role – A Sequential Multiple Method Study.

### **Introduction**

Explain the purpose of the study and why the participant has been chosen to take part. Explain confidentiality and data processing. (Public Health is the science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention).

### **START RECORDING HERE**

### **Policy Involvement (Follow-up questions as appropriate)**

1. In your view how clearly defined is your public health role in your job description or person specification?
2. How often is your job description or person specification reviewed to take account of emerging policies?
3. When considering your day-to-day activities, are there activities you undertake which you can relate to public health policy and can you identify any of these policies?
4. How are you involved with public health policy implementation within your organisation?
5. What do you think are the public health priorities for people with learning disabilities?
6. What do you think are the limitations to implementation of public health policy for people with learning disabilities?

**That was the last question. I want to thank you again for taking time to participate in this meeting.**

**Appendix 6a:** List of learning disability nurses' professional networks (Stage 2)

<b>Network</b>	<b>Contact</b>
A2A National Network	<b>Rick Robson</b> <a href="mailto:Rick.Robson@sssft.nhs.uk">Rick.Robson@sssft.nhs.uk</a>
All Wales Senior Nurse Advisory Group (LD)	<b>Stephen Hughes</b> <a href="mailto:Stephen.hughes@nww-tr.wales.nhs.uk">Stephen.hughes@nww-tr.wales.nhs.uk</a>
National Network for Learning Disability Nursing (NNLDN)	<b>Michael Brown</b> <a href="mailto:Michaelj.brown@nhs.net">Michaelj.brown@nhs.net</a>
Profound & Multiple Learning Disability Networks	<b>Beverley Dawkins</b> <a href="mailto:Beverley.dawkins@mencap.org.uk">Beverley.dawkins@mencap.org.uk</a> <a href="http://www.PMLDnetwork.org">www.PMLDnetwork.org</a>
National Health Facilitation Network	<b>Mark Bradley</b> <a href="mailto:Mark.Bradley@oxleas.nhs.uk">Mark.Bradley@oxleas.nhs.uk</a>
Mental Health in Learning Disabilities Network	<b>Steve Hardy</b> <a href="mailto:Steven.hardy@kcl.ac.uk">Steven.hardy@kcl.ac.uk</a>
National Learning Disability & Ethnicity Network	<b>Bridget Fisher/Pam Smith</b> <a href="mailto:Bridget.fisher@arcuk.org.uk">Bridget.fisher@arcuk.org.uk</a> <a href="http://www.liden.org.uk">www.liden.org.uk</a>
National Network for Palliative Care for Children with a Learning Disability	<b>Linda McEnhill</b> <a href="mailto:LindaMcEnhill@natnetpald.org.uk">LindaMcEnhill@natnetpald.org.uk</a>
National Network for Palliative Care for People with a Learning Disability (NNPCPLD)	<b>Linda McEnhill</b> <a href="mailto:LindaMcEnhill@natnetpald.org.uk">LindaMcEnhill@natnetpald.org.uk</a>
RCN Learning Disability Forum	<a href="mailto:Anne.norman@rcn.org.uk">Anne.norman@rcn.org.uk</a>
Nurse Consultants Network	<a href="mailto:Michealj.brown@nhs.net">Michealj.brown@nhs.net</a>
UK Health and Learning Disability Network	<b>Janet Cobb</b> <a href="mailto:jcobb@fpld.org.uk">jcobb@fpld.org.uk</a> <a href="http://www.learningdisabilities.org.uk/ldhn">www.learningdisabilities.org.uk/ldhn</a>
UK CAMHS and Learning Disability Network	<b>Janet Cobb</b> <a href="mailto:LearningDisability@camhs.org.uk">LearningDisability@camhs.org.uk</a> <a href="http://www.jan-net.co.uk">www.jan-net.co.uk</a>
UK Forensic and Learning Disability Network	<b>Janet Cobb</b> <a href="mailto:janet@jan-net.co.uk">janet@jan-net.co.uk</a> <a href="http://www.jan-net.co.uk">www.jan-net.co.uk</a>
UK Continuing Care Network (Learning Disability)	<b>Janet Cobb</b> <a href="mailto:janet@jan-net.co.uk">janet@jan-net.co.uk</a> <a href="http://www.jan-net.co.uk">www.jan-net.co.uk</a>
UK Epilepsy Network	<b>Janet Cobb</b> <a href="mailto:janet@jan-net.co.uk">janet@jan-net.co.uk</a> <a href="http://www.jan-net.co.uk">www.jan-net.co.uk</a>
NHS Networks	<a href="http://www.networks.nhs.uk">www.networks.nhs.uk</a>
<b>Regional Networks</b>	
A2A West Midlands Regional Network	<b>Dawn Harborne /Karen Breese</b> <a href="mailto:Dawn.harborne@solihull-ct.nhs.uk">Dawn.harborne@solihull-ct.nhs.uk</a> <a href="mailto:Karen.breese@sssft.nhs.uk">Karen.breese@sssft.nhs.uk</a>
A2A East Midlands Regional Network	<b>Marianne Duffy/Laura Summers</b> <a href="mailto:Marianne.Duffy@northants.nhs.uk">Marianne.Duffy@northants.nhs.uk</a> <a href="mailto:laura.summers@lcrpct.nhs.uk">laura.summers@lcrpct.nhs.uk</a>
A2A South East Network	<b>Sarah Lalljee</b> <a href="mailto:Sarah.lalljee@sabp.nhs.uk">Sarah.lalljee@sabp.nhs.uk</a>

<b>Network</b>	<b>Contact</b>
A2A South West Regional	<b>Liz Jennings/Annie Bowdler/Leslie Smith/Tanya Drew</b> <a href="mailto:Liz.Jennings@rdefn.nhs.uk">Liz.Jennings@rdefn.nhs.uk</a> <a href="mailto:annie.bowdler@pcs-tr.swest.nhs.uk">annie.bowdler@pcs-tr.swest.nhs.uk</a> <a href="mailto:tanya.drew@nhs.net">tanya.drew@nhs.net</a> <a href="mailto:Lesley.Smith2@pcs-tr.swest.nhs.uk">Lesley.Smith2@pcs-tr.swest.nhs.uk</a>
A2A Yorkshire, Humber and North East Regional Network	<b>Allyson Kent</b> <a href="mailto:Allyson.kent@humber.nhs.uk">Allyson.kent@humber.nhs.uk</a>
West Midlands Health Facilitation & A2A Network	<b>Jo Corbett/Dawn Harborne/Karen Breese</b> <a href="mailto:jo.corbett@blt-pct.nhs.uk">jo.corbett@blt-pct.nhs.uk</a> <a href="mailto:Dawn.harborne@solihull-ct.nhs.uk">Dawn.harborne@solihull-ct.nhs.uk</a> <a href="mailto:Karen.breese@sssf.nhs.uk">Karen.breese@sssf.nhs.uk</a>
London Network of Learning Disability Nurses incorporating the A2A London Regional Network	<b>Alison Pointu / Sarah Burchell</b> <a href="mailto:alison.pointu@barnet-pct.nhs.uk">alison.pointu@barnet-pct.nhs.uk</a> <a href="mailto:sarah.burchell@oxleas.nhs.uk">sarah.burchell@oxleas.nhs.uk</a>
Scottish Community LD Nursing Network (SCLDNN)	<a href="http://www.sclld.org.uk/">www.sclld.org.uk/</a>
Scottish Senior Nurse Network	<b>Contact via LD Nurse Consultants Network</b>
Learning Disabilities Managed Care Network South East Scotland	<b>Kay Ferguson or Tom Hammond</b> <a href="mailto:Katherineferguson@nhs.net">Katherineferguson@nhs.net</a> <a href="mailto:Tom.Hammond@nhs.net">Tom.Hammond@nhs.net</a> 01786 434721 / 01786 434765
The Scottish Learning Disability Nurse Education Forum	<b>Elaine Kwiatek</b> <a href="mailto:elaine.kwiatek@nes.scot.nhs.uk">elaine.kwiatek@nes.scot.nhs.uk</a>
South East Community Nursing	<b>Daniel Marsden</b> <a href="mailto:Daniel.marsden@nhs.net">Daniel.marsden@nhs.net</a>
South East Health Group	<b>Phil Boulter</b> <a href="mailto:Phil.boulter@surreyoaklands.nhs.uk">Phil.boulter@surreyoaklands.nhs.uk</a>
South East Person Centred Health Action Planning Group	<b>Phil Boulter/Jo Poynter/Tracy Watson/Daniel Marsden</b> <a href="mailto:Phil.Boulter@surreyoaklands.nhs.uk">Phil.Boulter@surreyoaklands.nhs.uk</a> <a href="mailto:Tracy.Watson@berkshire.nhs.uk">Tracy.Watson@berkshire.nhs.uk</a> <a href="mailto:daniel.marsden@icc.wkentmht.nhs.uk">daniel.marsden@icc.wkentmht.nhs.uk</a>

## **Appendix 6b:** Online survey questionnaire (Stage 3)

### **SURVEY QUESTIONNAIRE**

#### **1. INVITATION AND GUIDANCE**

You have been invited to participate in this study because we believe that you are the most appropriate person to approach for assistance. We also believe that you would make essential and valuable contribution to the findings of the study. This study is open to NMC registered learning disability nurses of Band 5 grade or above who are currently working in the community or others who have a significant involvement with public health for people with learning disabilities.

The research study is being conducted over 2-3 years and covers England, Wales, Scotland, and Northern Ireland. It is concerned with how learning disability nurses understand and enact their role in public health policy implementation for people with learning disabilities.

I am confident that the information provided here and in the email sent to you is sufficient for you to make a decision to contribute to this study. However if you need further clarification please contact Kay Mafuba at:

College of Nursing Midwifery and Healthcare  
University of West London  
Paragon House  
Boston Manor Road  
Brentford  
Middlesex TW8 9GA  
Tel: 0208 209 4217  
Email:  
[kaymafuba@uwl.ac.uk](mailto:kaymafuba@uwl.ac.uk)

#### **DEFINITION OF PUBLIC HEALTH**

'The science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society' [Acheson Report, 1988]. For the purposes of this study Public Health has 3 key components:

1. The assessment and monitoring of the health of people with learning disabilities;
2. Health policies designed to solve identified local and national health problems; and
3. Access to preventative health initiatives by people with learning disabilities.

#### **CONSENT**

By completing this survey you are giving your consent for your responses to be used in this research study. You are also confirming that you have understood that your participation is voluntary and that you are free to discontinue at any time, without giving any reason.

You can be assured that all information collected as part of this research study will be treated in the strictest of confidence. NO PERSONAL INFORMATION about participants and their organizations will be identified in the data collected or in any published results.



## 2. PERSONAL INFORMATION

\*1. Male                  Female

\*2. Age: 30<      31-49      >50

\*3. Highest academic qualification: Diploma / Advanced Diploma      Degree  
Post-graduate Degree

\*4. Length of community nursing experience (years) : <1      1-4      >5

## 3. EMPLOYMENT

\*1. England      Wales      Scotland      Northern Ireland

\*2. Who is your current employer?

NHS

Local authority

Both

\*3. What is your current NHS grade [NHS equivalent]?

Band 5

Band 6

Band 7

Band 8+

## 4. JOB DESCRIPTIONS

**\*1. My public health role is clearly defined in my job description / person specification / work schedule.**

Strongly disagree

Disagree

Not sure

Agree

Strongly agree

**\*2. My job description and or person specification are regularly reviewed to take account of emerging public health and other policies.**

Strongly disagree

Disagree

Not sure

Agree

Strongly agree

**\*3. My day-to-day activities are consistent with my job description and or person specification.**

Strongly disagree

Disagree

Not sure

Agree

Strongly agree

## 5. PUBLIC HEALTH ROLES

**\*1. Learning disability nurses have or should have a key role in implementing public health policy for people with learning disabilities.**

Strongly disagree

Disagree  
Not sure  
Agree  
Strongly agree

**\*2. Delivering public health services for people with learning disabilities is an important role for the learning disability nurse.**

Strongly disagree  
Disagree  
Not sure  
Agree  
Strongly agree

**3. My role as a community learning disability nurse involves the following [tick all that apply]:**

Healthcare delivery  
Health education  
Health prevention and protection  
Facilitating access to health  
Health promotion  
Health surveillance  
Other (please specify)

### **Appendix 6c** – Participant invitation e-mail (Stage 3)

**From:** Kay Mafuba (mailto:Kay.Mafuba@uwl.ac.uk)

**Sent:** 13 July 2011 12:21

**Cc:** Kay Mafuba

**Subject:** RE: Research into the Public Health Role of Learning Disability Nurses.

Dear ALL

I am writing to you with regard a research study being undertaken by the College of Nursing Midwifery and Healthcare at the University of West London. The research study is being conducted over 2-3 years and covers England, Wales, Scotland and Northern Ireland. It is concerned with how learning disability nurses understand and enact their role in public health policy implementation. Current re-organisation of health and healthcare provision in the UK has highlighted the need to evaluate the contribution learning disability nurses make to healthcare provision for people with learning disabilities.

The research will result in a series of publications. The published literature review publication, which set the rationale for this research is attached.

You can be assured that all information collected as part of this research study will be treated in the strictest confidence. **NO PERSONAL INFORMATION** about participants and their organisations will be identified in the data collected or in any published results.

If you are willing to participate please **CLICK** on a link that corresponds to your current grade below. **(Please NOTE THAT BY COMPLETING THE ON-LINE QUESTIONNAIRE YOU ARE GIVING YOUR CONSENT TO PARTICIPATE IN THE RESEARCH).** Participating in this on-line survey **takes on average 10-15 minutes.**

Click Here [Band 5](#)

Click Here [Band 6](#)

Click Here [Band 7](#)

Click Here [Band 8+](#)

Thanks very much for agreeing to take part and supporting this very important study.

**IF YOU HAVE PARTICIPATED IN STAGE 2 OF THE RESEARCH YOU ARE NOT EXPECTED TO PARTICIPATE IN THIS STAGE.** May I request your assistance and forward this e-mail to all your colleagues and members of your professional networks.

Yours sincerely



**Kay MAFUBA (MA; PG Cert Research; Fellow HEA; CLTHE; BA; RNT; RNLD)**  
**PROGRAMME LEADER (Learning Disabilities)**

London College of Nursing, Midwifery & Healthcare

University of West London

Paragon House

Boston Manor Road

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Middlesex TW8 9GA

Tel: 0208 209 4217

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Web: <http://www.health.uwl.ac.uk>



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**Appendix 7a:** Word frequencies (examples) (Stage 1)

WORD	Count	Frequency (%)
health	1125	1.67
needs	455	0.67
development	433	0.64
people	424	0.63
policies	288	0.43
children	246	0.36
procedures	241	0.36
develop	229	0.34
provide	228	0.34
policy	226	0.33
mental	220	0.33
assessment	195	0.29
complex	184	0.27
patients	182	0.27
participate	154	0.23
role	154	0.23
contribute	153	0.23
promote	148	0.22
planning	141	0.21
physical	126	0.19
undertake	125	0.19
protection	106	0.16
education	103	0.15
legislation	89	0.13
programmes	88	0.13
implement	85	0.13
implementation	70	0.10
developing	68	0.10
facilitate	68	0.10
facilitation	66	0.10
improve	66	0.10
wellbeing	66	0.10
awareness	49	0.07
involvement	42	0.06
promoting	28	0.04

**Appendix 7b:** Initial free nodes (public health roles) (examples) (Stage 1)

<b>Free Nodes</b>	<b>Sources</b>	<b>References</b>
JD5-Contribute	36	148
JD5-Develop	39	122
JD5-Facilitate	23	47
JD5-Implement	33	57
JD5-Liaise	20	24
JD5-Participate	45	158
JD5-Plan	40	81
JD5-Promote	34	92
JD5-Reduce	3	3
JD6 - Advise	22	26
JD6 - Contribute	53	171
JD6 - Deliver	6	6
JD6 - Develop	27	35
JD6 - Educate	8	9
JD6 - Enable	27	40
JD6 - Facilitate	45	85
JD6 - Implement	34	43
JD6 - Improve	23	70
JD6 - Minimise	14	14
JD6 - Participate	28	33
JD6 - Promote	58	177
JD6 - Provide	64	268
JD6 - Reduce	9	9
JD6-Advise	22	26
JD6-Contribute	53	171
JD6-Deliver	27	40
JD6-Develop	64	252
JD6-Educate	8	9
JD6-Enable	27	40
JD6-Facilitate	46	86
JD6-Implement	52	102
JD6-Improve	22	69
JD6-Manage	54	102
JD6-Minimise	14	14
JD6P - Diabetes	1	1
JD6-Participate	57	188
JD6-Prevent	5	7
JD6-Promote	58	177
JD6-Provide	64	269
JD6-Reduce	4	4
JD6-Undertake	62	155

**Appendix 7c:** Ranked summary of roles by band (Stage 1)

<p><b>Band 5 (N = 63)</b></p> <ol style="list-style-type: none"> <li>1. Implement (30%) (24)</li> <li>2. Facilitate (19%) (15)</li> <li>3. Contribute (16%) (13)</li> <li>4. Promote (12%) (10)</li> <li>5. Develop (9%) (7)</li> <li>6. Liaise (9%) (7)</li> <li>7. Plan (4%) (3)</li> <li>8. Reduce inequalities (1%) (1)</li> </ol>	<p><b>Band 6 (N = 87)</b></p> <ol style="list-style-type: none"> <li>1. Implement (27%) (12)</li> <li>2. Facilitate (18%) (8)</li> <li>3. Reduce inequalities (15%) (7)</li> <li>4. Promote (13%) (6)</li> <li>5. Enable (9%) (4)</li> <li>6. Advise (7%) (3)</li> <li>7. Contribute (7%) (3)</li> <li>8. Develop (4%) (2)</li> </ol>
<p><b>Band 7 (N = 47)</b></p> <ol style="list-style-type: none"> <li>1. Implement (34%) (17)</li> <li>2. Reduce inequalities (16%) (8)</li> <li>3. Promote (14%) (7)</li> <li>4. Facilitate (12%) (6)</li> <li>5. Enable (10%) (5)</li> <li>6. Lead (8%) (4)</li> <li>7. Contribute (4%) (2)</li> <li>8. Liaise (2%) (1)</li> </ol>	<p><b>Band 8+ (N = 6)</b></p> <ol style="list-style-type: none"> <li>1. Enable (33%) (4)</li> <li>2. Lead (25%) (3)</li> <li>3. Evaluate (17%) (2)</li> <li>4. Develop (17%) (2)</li> <li>5. Contribute (8%) (1)</li> </ol>

**Appendix 7d:** Ranked summary of policies by band (Stage 1)

<p><b>Band 5 (N = 63)</b></p> <ol style="list-style-type: none"> <li>1. Health action plans (41%) (11)</li> <li>2. National service frameworks (19%) (5)</li> <li>3. Healthy lifestyles (18%) (5)</li> <li>4. Health facilitation (15%) (4)</li> <li>5. Valuing people (7%) (2)</li> </ol>	<p><b>Band 6 (N = 87)</b></p> <ol style="list-style-type: none"> <li>1. Health facilitation (29%) (9)</li> <li>2. Health screening (26%) (8)</li> <li>3. Health action plans (20%) (6)</li> <li>4. National service frameworks (10%) (3)</li> <li>5. Directed enhanced services (3%) (1)</li> <li>6. Diabetes (3%) (1)</li> <li>7. Obesity (3%) (1)</li> <li>8. Quality outcomes framework (3%) (1)</li> <li>9. Valuing people (3%) (1)</li> </ol>
<p><b>Band 7 (N = 47)</b></p> <ol style="list-style-type: none"> <li>1. Health screening (19%) (7)</li> <li>2. Health facilitation (14%) (5)</li> <li>3. Health action plans (13%) (5)</li> <li>4. Directed enhanced services (8%) (3)</li> <li>5. National service frameworks (8%) (3)</li> <li>6. Healthcare for all (8%) (3)</li> <li>7. Obesity (5%) (2)</li> <li>8. Sexual health (5%) (2)</li> <li>9. Smoking cessation (3%) (1)</li> <li>10. Cardiac diseases (3%) (1)</li> <li>11. Darzi (3%) (1)</li> <li>12. Equally well (3%) (1)</li> </ol>	<p><b>Band 8+ (N = 6)</b></p> <ol style="list-style-type: none"> <li>1. Valuing people (100%) (2)</li> </ol>



**Appendix 8a:** Data analysis stage 1 – Referenced 'line-by-line' data extracts

(Open Codes) (examples) (Stage 2)

1. **P5NHS7 - I think people were fire fighting and there was a very strong social services lead in the team who was fairly powerful and the same in the two other services** and so to try and modernise the service and try to bring the service up to date and try to work with our colleagues outside of the learning disability service its been a higher priority really but public health is to say mine and the one priority now to actually get in with that new public health person that she has some sort of joint strategy and I'm planning to get her on to about keeping health delivery so she's on my list. (Inter-agency and philosophical tensions)
2. P5NHS7 - I've now got some lists of people and I'm trying to check them against our registers because we don't want them doing health checks on people we don't know and they we're saying, well hang on a minute, **these registers are different to ours**, so there's work that needs to be done on that and again is another one of my targets to do that this year. (Demographic ignorance)
3. P5NHS7 - I think the limitations are where **we shouldn't be doing other people's jobs**, so for me its about making sure that we are doing what the learning disability nurse should be doing in terms with committing public health policy and not doing the job that perhaps the GP should be doing or what the community or district nurse should be doing or what the social worker should be doing or whoever else, we shouldn't be doing their jobs so we need to be clear about the boundaries of our own roles so for me that's

the limitation, of being really clear about is this a nursing role or isn't it.  
(Role ambiguity, role confusion and role conflict)

4. P5NHS7 - **When we were in hospitals we knew what we did.** We actually did a lot of social care work and when we went into the community some of us transferred that into the community, but its not the same job because we are in social care and you no longer need to do everything. So historically we brought that into the community, being all man to everyone. I think we are our worst enemies in terms of role clarity. If we came out and said, for example some specialist nurses, it is really clear what they do, but we came out and said I can do that and that. We picked up a whole load of stuff and I think we are victims of our own abilities because of the breath of our knowledge. I know I do things I shouldn't do because there is really no one else to do it. (Role ambiguity, role confusion and role conflict)
5. P8NHSG5 - My biggest challenge in Glasgow is working with public health consultants. I think that is because of the **inability to see people with learning disabilities as anything other than a chronic disease.** The public health consultants view LD not as a condition, because they are used to working with big chronic diseases in the population. They can't make that intellectual shift to say that it's not a condition and not a disease and that the condition will result in people having a number of diseases.  
(Professional ignorance)
6. P9BCC5 - Probably not in relation to learning disabilities, if it was a general public health review, then it would be up to me to go back to my manager and say, " **I think in the response to a new white paper that has come**

out, maybe I should review how my role might fit within this new white paper". (Role validation)

7. P9BCC5 - I think when you say public health policy, public health affects the entire population and I think you see the word "public health policy" and learning disability staff thinks it's not for them and public health staff think that doesn't include learning disabilities because learning disability services think about that. So I think **"public health policy" in itself, the words are problematic for people**, I think in learning disabilities the ownership always sits somewhere else and I think in a way it's a problem about compartmentalising various different things. (Dialogical definition) (Inter-agency and philosophical tensions)
8. P10NHSCWP7 - The Trust has also bolted onto my day-to-day job because before I was just in the learning disabilities division doing this work for the LD population but the Trust then needed to have somebody to take a lead for the whole organisation of public health, so medical director has got the overall umbrella lead and then I've got organisational, operational leadership. We've developed mental health facilitators for the mental health population and they've now come under my umbrella so **they bolt things on as you go into your job plan. So** when you re-look at your job description it doesn't marry up. (Role extension)
9. P10NHSCWP7 - It's aimed at a level that people with learning disabilities wouldn't understand and couldn't link into very easily and they're very reluctant to alter things to work for specific minority groups, so **for me the limitations are about not understanding our population** and how they

can work with them because there is ways around it. (Demographic ignorance)

10.P11N17 - I also think that public health to me, and this is not saying that anybody else is wrong, means something different, so to me public health is not just health facilitation or public health screening but I think to a lot of learning disability nurses it is. (Dialogical definition).

11.P11N17 - We work within a health and social care context, so up the line our manager is also a non-nurse and there is a perception that, public health work, prevention work is not supposed to be targeting those in the greatest need, it's about preventing things, yes but let's stay with the severe challenging behaviour, let's stay with the real complex problems in relation to people moving in and out of hospital, to consider setting up a group of 8-10 people to try and **help them promote their own health, it was not seen as a priority.** (Policy conflict)

12.P11N17 - First of all I think there is a lack of clarity about what public health means and public health does mean something different to addressing health inequalities, it is more than that, when I'm reading anything about improving healthcare and learning disability I'm reading about improving access to primary healthcare, I'm reading about health facilities, I'm reading about health screening, I'm reading about acute care liaison and of course that is part of public health. But to me public health needs to be considered as merely the science of public health and that is about needs assessment, so when you are working with a group of learning disability nurses or as any profession because I think public health goes beyond nursing, we should be doing things like needs assessments like health visitors have a core

function to needs assess the population, I think learning disability nurses should be required to do the same so I think there's that lack of understanding (Dialogical definition)

13.P11N17 - I think as well it hasn't been focused on enough within job descriptions I don't personally think that managers as they set up learning disability services give enough thought to the importance of job descriptions and how important they can be in dictating how going to have services. (Role ambiguity)

14.P11N17 - Our data collection depends on those known to services and that's another really important thing because the majority of people with learning disabilities are not known to services, those people will tend to be in the minor category of learning disabilities. (Demographic ignorance)

15.P11N17 - So we need to think about how to collect data, how to understand people and we also need to start really doing robust needs assessments, starting with health visitor colleagues in relation to the work that they do around needs assessment. (Demographic ignorance)

16.P14NHSH3 - It was worrying for example within there it only talked about only 40% of any acute hospitals are actually making some positive in-roads into the learning disability agenda and given that the Six Lives report was primarily focused on the acute sector, it's still slightly concerning that 18 months on, only 40% of acute hospitals are dealing with the issues. (Organisational inertia)

17.P14NHSH3 - You're not always privy even as a senior clinician, you're not always privy to some of the developments that are going on.  
(Organisational silo mentality)

18.P14NHSH3 - So we've got all that I think what we need to do not at a local level is pin that down and drill down so we get a more accurate picture of what the local situation is. (Demographic ignorance)

**Appendix 8b:** Data analysis stage 2 - Code clusters (examples) (Stage 2)

ID	NARRATIVE	Code Clusters
P16NHSB1	I had a phone call from Tony Blair's office when he was Prime Minister asking us to supply a nurse to go and meet him and then we got another phone call to say in that person's job description, 'what are they doing in relation to national policy around health?' So ever since then it taught me lessons that <b>we have national policy</b> and then <b>we have local policy</b> and how does my job fit into that national policy so it hasn't always been quite clear about national policy around health and how we break that down into local roles.	we have national policy we have local policy
P5NHS7	I've now got some lists of people and I'm trying to check them against our registers because we don't want them <b>doing health checks on people we don't know</b> and they we're saying, well hang on a minute, these registers are different to ours, so there's work that needs to be done on that and again is another one of my targets to do that this year.	people we don't know
P7NHS5	One of the things we are going to look at as we roll out the health check program as well is also the accuracy of that information, there are some concerns that some of the people that were identified through GPs as having learning disabilities don't actually have them, so <b>we are looking to do some validating of information</b> of the GP registers as well.	we are looking to do some validating of information
P8NHSG5	<b>What we don't know</b> is, the next big challenge is the <b>kids coming through</b> . If we can make any change, actually in the UK, it is to change the QOF, for the QOF registers to include children. We have just asked NICE to ask for submissions for changes to the QOF. I think <b>what we need is a register from cradle to grave</b> , for GPs to start identifying children that are coming through.	What we don't know kids coming through

**Appendix 9a:** Pearson correlation matrix of group variables ( $N = 171$ ) (Stage 3).

	Employer	Band	Q1	Q2	Q3	Q4	Q5	Q7	Q8
Employer	1	.293 <sup>*</sup> .000	.193 <sup>*</sup> .011	.178 <sup>*</sup> .020	.357 <sup>**</sup> .000	-.041 .593	-.099 .198	.205 <sup>**</sup> .007	.222 <sup>**</sup> .003
Band	.293 <sup>**</sup> .000	1	.149 .052	.188 <sup>*</sup> .014	.088 .253	-.068 .378	-.047 .539	.239 <sup>**</sup> .002	.136 .076
Q1 - Role Clarity	.193 <sup>*</sup> .011	.149 .052	1	.545 <sup>**</sup> .000	.556 <sup>**</sup> .000	-.006 .941	-.040 .606	.381 <sup>**</sup> .000	.417 <sup>**</sup> .000
Q2 - Role Review	.178 <sup>*</sup> .020	.188 <sup>*</sup> .014	.545 <sup>**</sup> .000	1	.322 <sup>**</sup> .000	-.096 .213	.006 .935	.413 <sup>**</sup> .000	.461 <sup>**</sup> .000
Q3 - Daily Activities	.357 <sup>**</sup> .000	.088 .253	.556 <sup>**</sup> .000	.322 <sup>**</sup> .000	1	-.118 .125	-.151 <sup>*</sup> .049	.245 <sup>**</sup> .001	.351 <sup>**</sup> .000
Q4 - Role Perception	-.041 .593	-.068 .378	-.006 .941	-.096 .213	-.118 .125	1	.619 <sup>**</sup> .000	.089 .247	.080 .299
Q5 - Role Value	-.099 .198	-.047 .539	-.040 .606	.006 .935	-.151 <sup>*</sup> .049	.619 <sup>**</sup> .000	1	.061 .431	.016 .833
Q7 - E. Priorities	.205 <sup>**</sup> .007	.239 <sup>*</sup> .002	.381 <sup>**</sup> .000	.413 <sup>**</sup> .000	.245 <sup>**</sup> .001	.089 .247	.061 .431	1	.647 <sup>**</sup> .000
Q8 - E. Knowledge	.222 <sup>**</sup> .003	.136 .076	.417 <sup>**</sup> .000	.461 <sup>**</sup> .000	.351 <sup>**</sup> .000	.080 .299	.016 .833	.647 <sup>**</sup> .000	1

**\*\*.** Correlation is significant at the 0.01 level (2-tailed).

**\***. Correlation is significant at the 0.05 level (2-tailed).



**Appendix 9b:** Pearson correlation matrix of combined variables ( $N = 171$ ) (Stage 3)

	Employer	Band	Q1	Q2	Q3	Q4	Q5	Q7	Q8
Employer	1	.293 <sup>*</sup> .000	.193 <sup>*</sup> .011	.178 <sup>*</sup> .020	.357 <sup>**</sup> .000	-.041 .593	-.099 .198	.205 <sup>**</sup> .007	.222 <sup>**</sup> .003
Band	.293 <sup>**</sup> .000	1	.149 .052	.188 <sup>*</sup> .014	.088 .253	-.068 .378	-.047 .539	.239 <sup>**</sup> .002	.136 .076
Q1 - Role Clarity	.193 <sup>*</sup> .011	.149 .052	1	.545 <sup>**</sup> .000	.556 <sup>**</sup> .000	-.006 .941	-.040 .606	.381 <sup>**</sup> .000	.417 <sup>**</sup> .000
Q2 - Role Review	.178 <sup>*</sup> .020	.188 <sup>*</sup> .014	.545 <sup>**</sup> .000	1	.322 <sup>**</sup> .000	-.096 .213	.006 .935	.413 <sup>**</sup> .000	.461 <sup>**</sup> .000
Q3 - Daily Activities	.357 <sup>**</sup> .000	.088 .253	.556 <sup>**</sup> .000	.322 <sup>**</sup> .000	1	-.118 .125	-.151 <sup>*</sup> .049	.245 <sup>**</sup> .001	.351 <sup>**</sup> .000
Q4 - Role Perception	-.041 .593	-.068 .378	-.006 .941	-.096 .213	-.118 .125	1	.619 <sup>**</sup> .000	.089 .247	.080 .299
Q5 - Role Value	-.099 .198	-.047 .539	-.040 .606	.006 .935	-.151 <sup>*</sup> .049	.619 <sup>**</sup> .000	1	.061 .431	.016 .833
Q7 - E. Priorities	.205 <sup>**</sup> .007	.239 <sup>*</sup> .002	.381 <sup>**</sup> .000	.413 <sup>**</sup> .000	.245 <sup>**</sup> .001	.089 .247	.061 .431	1	.647 <sup>**</sup> .000
Q8 - E. Knowledge	.222 <sup>**</sup> .003	.136 .076	.417 <sup>**</sup> .000	.461 <sup>**</sup> .000	.351 <sup>**</sup> .000	.080 .299	.016 .833	.647 <sup>**</sup> .000	1

**\*\*.** Correlation is significant at the 0.01 level (2-tailed).

**\***. Correlation is significant at the 0.05 level (2-tailed).



